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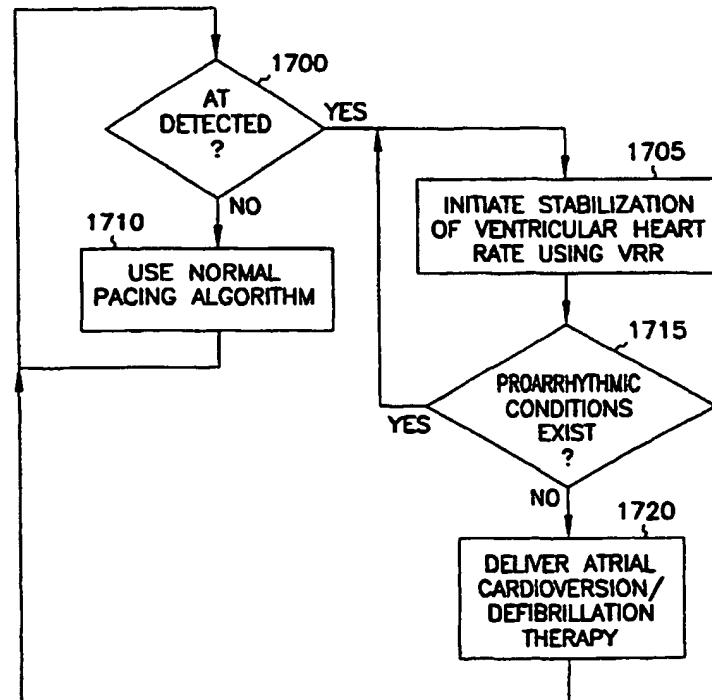
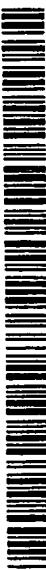
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(54) Title: SYSTEM WITH SHOCK TIMING OPTIMIZATION



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the atrial cardioversion/defibrillation therapy will induce a ventricular arrhythmia.

(57) Abstract: A cardiac rhythm management system includes atrial shock timing optimization. Because an atrial tachyarrhythmia, such as atrial fibrillating typically causes significant variability in the ventricular heart rate, resulting in potentially proarrhythmic conditions. The system avoids delivering atrial cardioversion/defibrillation therapy during potentially proarrhythmic conditions because doing so could result in dangerous ventricular arrhythmias. Using Ventricular Rate Regularization ("VRR") techniques, the system actively stabilizes the ventricular heart rate to obtain less potentially proarrhythmic conditions for delivering the atrial tachyarrhythmia therapy. The intrinsic ventricular heart rate is stabilized at a variable VRR-indicated rate, computed using an infinite impulse response (IIR) filter, and based on the underlying intrinsic ventricular heart rate. The system withholds delivery of atrial cardioversion/defibrillation therapy until the intervals between ventricular beats ("V-V intervals") meet certain criteria that decrease the chance that

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*For two-letter codes and other abbreviations, refer to the "Guidance Notes on Codes and Abbreviations" appearing at the beginning of each regular issue of the PCT Gazette.*

**SYSTEM WITH SHOCK TIMING OPTIMIZATION****Cross Reference To Related Applications**

This application is related to the following co-pending, commonly assigned patent applications: "Method and Apparatus for Treating Irregular Ventricular Contractions Such as During Atrial Arrhythmia," serial number 5 09/316,515, (Attorney Docket No. 00279.112US1); "Cardiac Rhythm Management System Promoting Atrial Pacing," serial number 09/316,682, (Attorney Docket No. 00279.113US1); and "System Providing Ventricular Pacing and Biventricular Coordination," serial number 09/316,588, (Attorney Docket No. 00279.160US1); each of which are filed on even date herewith, each 10 of which disclosure is herein incorporated by reference in its entirety.

**Technical Field**

This invention relates generally to cardiac rhythm management systems and particularly, but not by way of limitation, to a cardiac rhythm management system with atrial shock timing optimization.

**Background**

When functioning properly, the human heart maintains its own intrinsic rhythm, and is capable of pumping adequate blood throughout the body's circulatory system. However, some people have irregular cardiac rhythms, referred to as cardiac arrhythmias. Such arrhythmias result in diminished blood 20 circulation. One mode of treating cardiac arrhythmias uses drug therapy. Drugs are often effective at restoring normal heart rhythms. However, drug therapy is not always effective for treating arrhythmias of certain patients. For such 25 patients, an alternative mode of treatment is needed. One such alternative mode of treatment includes the use of a cardiac rhythm management system. Such systems are often implanted in the patient and deliver therapy to the heart.

Cardiac rhythm management systems include, among other things, pacemakers, also referred to as pagers. Pagers deliver timed sequences of low energy electrical stimuli, called pace pulses, to the heart, such as via a transvenous leadwire or catheter (referred to as a "lead") having one or more 30 electrodes disposed in or about the heart. Heart contractions are initiated in response to such pace pulses (this is referred to as "capturing" the heart). By

properly timing the delivery of pace pulses, the heart can be induced to contract in proper rhythm, greatly improving its efficiency as a pump. Pacers are often used to treat patients with bradyarrhythmias, that is, hearts that beat too slowly, or irregularly.

5        Cardiac rhythm management systems also include cardioverters or defibrillators that are capable of delivering higher energy electrical stimuli to the heart. Defibrillators are often used to treat patients with tachyarrhythmias, that is, hearts that beat too quickly. Such too-fast heart rhythms also cause diminished blood circulation because the heart isn't allowed sufficient time to  
10      fill with blood before contracting to expel the blood. Such pumping by the heart is inefficient. A defibrillator is capable of delivering an high energy electrical stimulus that is sometimes referred to as a defibrillation countershock. The countershock interrupts the tachyarrhythmia, allowing the heart to reestablish a normal rhythm for the efficient pumping of blood. In addition to pacers, cardiac  
15      rhythm management systems also include, among other things, pacer/defibrillators that combine the functions of pacers and defibrillators, drug delivery devices, and any other systems or devices for diagnosing or treating cardiac arrhythmias.

One problem faced by cardiac rhythm management systems is the proper  
20      treatment of atrial tachyarrhythmias, such as atrial fibrillation. Atrial fibrillation is a common cardiac arrhythmia which reduces the pumping efficiency of the heart, though not to as great a degree as in ventricular fibrillation. However, this reduced pumping efficiency requires the ventricle to work harder, which is particularly undesirable in sick patients that cannot tolerate additional stresses.  
25      As a result of atrial fibrillation, patients must typically limit their activity and exercise.

Although atrial fibrillation, by itself, is usually not life-threatening, prolonged atrial fibrillation may be associated with strokes, which are thought to be caused by blood clots forming in areas of stagnant blood flow. Treating such  
30      blood clots requires the use of anticoagulants. Atrial fibrillation may also cause pain, dizziness, and other irritation to the patient.

An even more serious problem, however, is the risk that atrial fibrillation may induce irregular ventricular heart rhythms by processes that are yet to be

fully understood. Moreover, treatment of atrial fibrillation may also induce irregular ventricular heart rhythms. Such induced ventricular arrhythmias compromise pumping efficiency even more drastically than atrial arrhythmias and, in some instances, may be life-threatening. For these and other reasons,  
5 there is a need for safe and more effective treatment of atrial fibrillation that avoids inducing ventricular arrhythmias.

### **Summary**

The present cardiac rhythm management system provides, among other things, atrial shock timing optimization. The system detects an atrial  
10 tachyarrhythmia, such as atrial fibrillation. Such atrial tachyarrhythmias typically cause significant variability in the ventricular heart rate. The present system avoids delivering atrial cardioversion/defibrillation therapy during such irregular ventricular heart activity, because such conditions may be potentially proarrhythmic, such that delivering atrial cardioversion/defibrillation therapy  
15 could result in dangerous ventricular arrhythmias. Using Ventricular Rate Regularization (“VRR”) techniques described below, the system stabilizes the ventricular heart rate to obtain less potentially proarrhythmic conditions for delivering the atrial tachyarrhythmia therapy. The system withholds delivery of atrial cardioversion/defibrillation therapy until the intervals between ventricular  
20 beats (“V-V intervals”) meet certain criteria that decrease the chance that the atrial cardioversion/defibrillation therapy will induce a ventricular arrhythmia.

In one embodiment, the system includes a first method. The first method includes: (a) detecting an atrial tachyarrhythmia, (b) stabilizing a ventricular heart rate at a variable indicated rate based on an underlying intrinsic ventricular  
25 heart rate, (c) determining if potentially proarrhythmic conditions exist based on V-V intervals between ventricular events, and (d) delivering cardioversion/defibrillation therapy to the atrium if step (c) indicates no potentially proarrhythmic conditions exist, otherwise withholding the delivery of cardioversion/defibrillation therapy to the atrium until conditions become less  
30 potentially proarrhythmic.

In another embodiment, the system includes a second method. The second method includes: (a) obtaining V-V intervals between ventricular beats, (b) computing a first indicated pacing interval based on at least a most recent V-

V interval duration and a previous value of the first indicated pacing interval, (c) providing pacing therapy, based on the first indicated pacing interval, (d) detecting a tachyarrhythmia in an atrium, and (e) delivering cardioversion/defibrillation therapy to the atrium.

5 In another embodiment, the system includes a cardiac rhythm management device. The device includes an atrial heart sensing circuit, a ventricular heart sensing circuit, a ventricular pacing therapy circuit, an atrial cardioversion/defibrillation therapy circuit, and a controller. The controller includes a ventricular rate stabilization module that stabilizes a ventricular heart  
10 rate at a variable indicated rate based on an underlying intrinsic ventricular heart rate. The controller also includes an atrial cardioversion/defibrillation control module that (a) determines if potentially proarrhythmic conditions exist based on V-V intervals between ventricular events, and (b) delivers cardioversion/defibrillation therapy to the atrium if conditions become less  
15 potentially proarrhythmic, and otherwise withholds the delivery of cardioversion/defibrillation therapy to the atrium. Other aspects of the invention will be apparent on reading the following detailed description of the invention and viewing the drawings that form a part thereof.

#### Brief Description of the Drawings

20 In the drawings, like numerals describe substantially similar components throughout the several views. Like numerals having different letter suffixes represent different instances of substantially similar components.

Figure 1 is a schematic drawing illustrating one embodiment of portions of a cardiac rhythm management system and an environment in which it is used.

25 Figure 2 is a schematic drawing illustrating one embodiment of a cardiac rhythm management device coupled by leads to portions of a heart.

Figure 3 is a schematic diagram illustrating generally one embodiment of portions of a cardiac rhythm management device which is coupled to a heart.

30 Figure 4 is a schematic diagram illustrating generally one embodiment of a controller that includes several different inputs to modify the rate at which pacing or other therapy is delivered.

Figure 5 is a schematic diagram illustrating generally one conceptualization of portions of a controller.

Figure 6 is a signal flow diagram illustrating generally one embodiment of operating a filter.

Figure 7 is a signal flow diagram illustrating generally aspects of another conceptualization of operating the filter.

5 Figure 8 is a signal flow diagram illustrating generally aspects of a further conceptualization of operating the filter.

Figure 9 is a schematic diagram illustrating generally another conceptualization of portions of a controller.

10 Figure 10 is a schematic diagram illustrating generally a further conceptualization of portions of the controller.

Figure 11 is a graph illustrating generally one embodiment of operating a filter to provide a first indicated rate, such as a Ventricular Rate Regularization (“VRR”) indicated rate, for successive ventricular heart beats.

15 Figure 12 is a graph illustrating generally another embodiment of operating a filter to provide a first indicated pacing rate, such as a VRR indicated rate, and delivering therapy based on the first indicated pacing rate and based on a second indicated pacing rate, such as a sensor indicated rate.

Figure 13 is a graph illustrating generally another illustrative example of heart rate vs. time according to a VRR algorithm spreadsheet simulation.

20 Figure 14 is a graph illustrating generally one embodiment of using at least one of coefficients  $a$  and  $b$  as a function of heart rate (or corresponding time interval).

Figure 15 is a schematic diagram illustrating generally another embodiment of a cardiac rhythm management device which is coupled to a heart.

25 Figure 16 is a schematic diagram illustrating generally another embodiment of portions of a cardiac rhythm management device which is coupled to a heart.

Figure 17 is a flow chart illustrating generally one embodiment of operating a cardiac rhythm management device for delivering atrial cardioversion/defibrillation therapy to terminate an atrial tachyarrhythmia, such as atrial fibrillation, and enable the resumption of normal atrial heart rhythms.

30 Figure 18 is a flow chart illustrating generally one embodiment of determining whether potentially proarrhythmic conditions exist.

Figure 19 is a chart further illustrating generally one embodiment of determining whether potentially proarrhythmic conditions exist, such as described with respect to Figure 18.

Figure 20 is a flow chart, similar to Figure 17, illustrating generally an 5 embodiment of operating a cardiac rhythm management device in which stabilization of the ventricular heart rate using the VRR algorithm is independent of whether atrial tachyarrhythmias are detected.

Figure 21 is a flow chart, similar to Figure 18, illustrating generally an 10 embodiment of operating a cardiac rhythm management device using different comparison values for sensed and paced ventricular beats.

#### Detailed Description

In the following detailed description, reference is made to the accompanying drawings which form a part hereof, and in which is shown by way of illustration specific embodiments in which the invention may be practiced.

15 These embodiments are described in sufficient detail to enable those skilled in the art to practice the invention, and it is to be understood that the embodiments may be combined, or that other embodiments may be utilized and that structural, logical and electrical changes may be made without departing from the spirit and scope of the present invention. The following detailed description is, therefore, 20 not to be taken in a limiting sense, and the scope of the present invention is defined by the appended claims and their equivalents. In the drawings, like numerals describe substantially similar components throughout the several views. Like numerals having different letter suffixes represent different instances of substantially similar components.

#### General Overview

This document describes, among other things, a cardiac rhythm management system with atrial shock timing optimization. The system detects an atrial tachyarrhythmia, such as atrial fibrillation. Such atrial tachyarrhythmias typically cause significant variability in the ventricular heart rate. The present 30 system avoids delivering atrial cardioversion/defibrillation therapy during such irregular ventricular heart activity, because such conditions may be potentially proarrhythmic, such that delivering atrial cardioversion/defibrillation therapy could result in dangerous ventricular arrhythmias. Using Ventricular Rate

Regularization (“VRR”) techniques described below, the system stabilizes the ventricular heart rate to obtain less potentially proarrhythmic conditions for delivering the atrial tachyarrhythmia therapy. The system withholds delivery of atrial cardioversion/defibrillation therapy until the intervals between ventricular 5 beats (“V-V intervals”) meet certain criteria that decrease the chance that the atrial cardioversion/defibrillation therapy will induce a ventricular arrhythmia.

#### VENTRICULAR RATE REGULARIZATION (VRR) EXAMPLE

One aspect of the present system includes actively stabilizing the ventricular heart rate to obtain less potentially proarrhythmic conditions for 10 delivering the atrial tachyarrhythmia therapy. One suitable technique for stabilizing ventricular heart rate is referred to as Ventricular Rate Regularization (“VRR”), described in Krig et al. U.S. Patent Application Serial No. 09/316,515, entitled “Method and Apparatus For Treating Irregular Ventricular Contractions Such As During Atrial Arrhythmia,” which is filed on even date herewith, 15 assigned to the assignee of the present patent application, and which is herein incorporated by reference in its entirety.

#### General System Overview and Examples

Figure 1 is a schematic drawing illustrating, by way of example, but not by way of limitation, one embodiment of portions of a cardiac rhythm 20 management system 100 and an environment in which it is used. In Figure 1, system 100 includes an implantable cardiac rhythm management device 105, also referred to as an electronics unit, which is coupled by an intravascular endocardial lead 110, or other lead, to a heart 115 of patient 120. System 100 also includes an external programmer 125 providing wireless communication 25 with device 105 using a telemetry device 130. Catheter lead 110 includes a proximal end 135, which is coupled to device 105, and a distal end 140, which is coupled to one or more portions of heart 115.

Figure 2 is a schematic drawing illustrating, by way of example, but not by way of limitation, one embodiment of device 105 coupled by leads 110A-B to 30 heart 115, which includes a right atrium 200A, a left atrium 200B, a right ventricle 205A, a left ventricle 205B, and a coronary sinus 220 extending from right atrium 200A. In this embodiment, atrial lead 110A includes electrodes (electrical contacts) disposed in, around, or near an atrium 200 of heart 115, such

as ring electrode 225 and tip electrode 230, for sensing signals and/or delivering pacing therapy to the atrium 200. Lead 110A optionally also includes additional electrodes, such as for delivering atrial and/or ventricular cardioversion/defibrillation and/or pacing therapy to heart 115.

5 In Figure 2, a ventricular lead 110B includes one or more electrodes, such as tip electrode 235 and ring electrode 240, for delivering sensing signals and/or delivering pacing therapy. Lead 110B optionally also includes additional electrodes, such as for delivering atrial and/or ventricular cardioversion/defibrillation and/or pacing therapy to heart 115. Device 105  
10 includes components that are enclosed in a hermetically-sealed can 250. Additional electrodes may be located on the can 250, or on an insulating header 255, or on other portions of device 105, for providing unipolar pacing and/or defibrillation energy in conjunction with the electrodes disposed on or around heart 115. Other forms of electrodes include meshes and patches which may be  
15 applied to portions of heart 115 or which may be implanted in other areas of the body to help "steer" electrical currents produced by device 105. The present method and apparatus will work in a variety of configurations and with a variety of electrical contacts or "electrodes."

#### Example Cardiac Rhythm Management Device

20 Figure 3 is a schematic diagram illustrating generally, by way of example, but not by way of limitation, one embodiment of portions of device 105, which is coupled to heart 115. Device 105 includes a power source 300, an atrial sensing circuit 305, a ventricular sensing circuit 310, a ventricular therapy circuit 320, and a controller 325.

25 Atrial sensing circuit 305 is coupled by atrial lead 110A to heart 115 for receiving, sensing, and/or detecting electrical atrial heart signals. Such atrial heart signals include atrial activations (also referred to as atrial depolarizations or P-waves), which correspond to atrial contractions. Such atrial heart signals include normal atrial rhythms, and abnormal atrial rhythms including atrial  
30 tachyarrhythmias, such as atrial fibrillation, and other atrial activity. Atrial sensing circuit 305 provides one or more signals to controller 325, via node/bus 327, based on the received atrial heart signals. Such signals provided to controller 325 indicate, among other things, the presence of atrial fibrillation.

Ventricular sensing circuit 310 is coupled by ventricular lead 110B to heart 115 for receiving, sensing, and/or detecting electrical ventricular heart signals, such as ventricular activations (also referred to as ventricular depolarizations or R-waves), which correspond to ventricular contractions. Such 5 ventricular heart signals include normal ventricular rhythms, and abnormal ventricular rhythms, including ventricular tachyarrhythmias, such as ventricular fibrillation, and other ventricular activity, such as irregular ventricular contractions resulting from conducted signals from atrial fibrillation. Ventricular sensing circuit 310 provides one or more signals to controller 325, via node/bus 10 327, based on the received ventricular heart signals. Such signals provided to controller 325 indicate, among other things, the presence of ventricular depolarizations, whether regular or irregular in rhythm.

Ventricular therapy circuit 320 provides ventricular pacing therapy, as appropriate, to electrodes located at or near one of the ventricles 205 of heart 115 15 for obtaining resulting evoked ventricular depolarizations. In one embodiment, ventricular therapy circuit 320 also provides cardioversion/defibrillation therapy, as appropriate, to electrodes located at or near one of the ventricles 205 of heart 115, for terminating ventricular fibrillation and/or other ventricular tachyarrhythmias.

20 Controller 325 controls the delivery of therapy by ventricular therapy circuit 320 and/or other circuits, based on heart activity signals received from atrial sensing circuit 305 and ventricular sensing circuit 310, as discussed below. Controller 325 includes various modules, which are implemented either in hardware or as one or more sequences of steps carried out on a microprocessor or 25 other controller. Such modules are illustrated separately for conceptual clarity; it is understood that the various modules of controller 325 need not be separately embodied, but may be combined and/or otherwise implemented, such as in software/firmware.

In general terms, sensing circuits 305 and 310 sense electrical signals 30 from heart tissue in contact with the catheter leads 110A-B to which these sensing circuits 305 and 310 are coupled. Sensing circuits 305 and 310 and/or controller 325 process these sensed signals. Based on these sensed signals, controller 325 issues control signals to therapy circuits, such as ventricular

therapy circuit 320, if necessary, for the delivery of electrical energy (e.g., pacing and/or defibrillation pulses) to the appropriate electrodes of leads 110A-

B. Controller 325 may include a microprocessor or other controller for execution of software and/or firmware instructions. The software of controller

5 325 may be modified (e.g., by remote external programmer 105) to provide different parameters, modes, and/or functions for the implantable device 105 or to adapt or improve performance of device 105.

In one further embodiment, one or more sensors, such as sensor 330, may serve as inputs to controller 325 for adjusting the rate at which pacing or other 10 therapy is delivered to heart 115. One such sensor 330 includes an accelerometer that provides an input to controller 325 indicating increases and decreases in physical activity, for which controller 325 increases and decreases 15 pacing rate, respectively. Another such sensor includes an impedance measurement, obtained from body electrodes, which provides an indication of increases and decreases in the patient's respiration, for example, for which controller 325 increases and decreases pacing rate, respectively. Any other 20 sensor 330 providing an indicated pacing rate can be used.

Figure 4 is a schematic diagram illustrating generally, by way of example, but not by way of limitation, one embodiment of controller 325 that 25 includes several different inputs to modify the rate at which pacing or other therapy is delivered. For example, Input #1 may provide information about left ventricular rate, Input #2 may provide an accelerometer-based indication of activity, and Input #3 may provide an impedance-based indication of respiration, such as minute ventilation. Based on at least one of these and/or other inputs, 30 controller 325 provides an output indication of pacing rate as a control signal delivered to a therapy circuit, such as to ventricular therapy circuit 320.

Ventricular therapy circuit 320 issues pacing pulses based on one or more such control signals received from controller 325. Control of the pacing rate may be performed by controller 325, either alone or in combination with peripheral 35 circuits or modules, using software, hardware, firmware, or any combination of the like. The software embodiments provide flexibility in how inputs are processed and may also provide the opportunity to remotely upgrade the device

software while still implanted in the patient without having to perform surgery to remove and/or replace the device 105.

Controller Example 1

Figure 5 is a schematic diagram illustrating generally, by way of example, but not by way of limitation, one conceptualization of portions of controller 325. At least one signal from ventricular sensing circuit 310 is received by ventricular event module 500, which recognizes the occurrence of ventricular events included within the signal. Such events are also referred to as "beats," "activations," "depolarizations," "QRS complexes," "R-waves," "contractions." Ventricular event module 500 detects intrinsic events (also referred to as sensed events) from the signal obtained from ventricular sensing circuit 310. Ventricular event module 500 also detects evoked events (resulting from a pace) either from the signal obtained from ventricular sensing circuit 310, or preferably from a ventricular pacing control signal obtained from pacing control module 505, which also triggers the delivery of a pacing stimulus by ventricular therapy circuit 320. Thus, ventricular events include both intrinsic/sensed events and evoked/paced events.

A time interval between successive ventricular events, referred to as a V-V interval, is recorded by a first timer, such as V-V interval timer 510. A filter 515 computes a "first indicated pacing interval," i.e., one indication of a desired time interval between ventricular events or, stated differently, a desired ventricular heart rate. The first indicated pacing interval is also referred to as a ventricular rate regularization (VRR) indicated pacing interval. In various embodiments, filter 515 includes an averager, a weighted averager, a median filter, an infinite impulse response (IIR) filter, a finite impulse response (FIR) filter, or any other analog or digital signal processing circuit providing the desired signal processing described more particularly below.

In one embodiment, filter 515 computes a new value of the first indicated pacing interval based on the duration of the most recent V-V interval recorded by timer 510 and on a previous value of the first indicated pacing interval stored in first indicated pacing interval register 520. Register 520 is then updated by storing the newly computed first indicated pacing interval in register 520. Based on the first indicated pacing interval stored in register 520, pacing control

module 505 delivers control signals to ventricular therapy circuit 320 for delivering therapy, such as pacing stimuli, at the VRR-indicated ventricular heart rate corresponding to the inverse of the duration of the first indicated pacing interval.

5

#### Filter Example 1

In general terms, for one embodiment, device 105 obtains V-V intervals between successive sensed or evoked ventricular beats. Device 105 computes a new first indicated pacing interval based at least in part on the duration of the most recent V-V interval and a previous value of the first indicated pacing 10 interval. Device 105 provides pacing therapy delivered at a rate corresponding to the inverse of the duration of the first indicated pacing interval.

Figure 6 is a signal flow diagram illustrating generally, by way of example, but not by way of limitation, one embodiment of operating filter 515. Upon the occurrence of a sensed or evoked ventricular beat, timer 510 provides 15 filter 515 with the duration of the V-V interval concluded by that beat, which is referred to as the most recent V-V interval ( $VV_n$ ). Filter 515 also receives the previous value of the first indicated pacing interval ( $T_{n-1}$ ) stored in register 520. The most recent V-V interval  $VV_n$  and the previous value of the first indicated 20 pacing interval  $T_{n-1}$  are each scaled by respective constants  $A$  and  $B$ , and then summed to obtain a new value of the first indicated pacing interval ( $T_n$ ), which is stored in register 520 and provided to pacing control module 505. In one embodiment, the coefficients  $A$  and  $B$  are different values, and are either programmable, variable, or constant.

If no ventricular beat is sensed during the new first indicated pacing 25 interval  $T_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse upon the expiration of the new first indicated pacing interval  $T_n$ . In one embodiment, operation of the filter is described by  $T_n = A \cdot VV_n + B \cdot T_{n-1}$ , where  $A$  30 and  $B$  are coefficients (also referred to as "weights"),  $VV_n$  is the most recent V-V interval duration, and  $T_{n-1}$  is the previous value of the first indicated pacing interval.

Initialization of filter 515 includes seeding the filter by storing, in register 520, an initial interval value. In one embodiment, register 520 is initialized to an interval value corresponding to a lower rate limit (LRL), i.e., a minimum rate at which pacing pulses are delivered by device 105. Register 520 could 5 alternatively be initialized with any other suitable value.

#### Filter Example 2

In one embodiment, operation of filter 515 is based on whether the beat concluding the most recent V-V interval  $VV_n$  is a sensed/intrinsic beat or a paced/evoked beat. In this embodiment, the pacing control module 505, which 10 controls the timing and delivery of pacing pulses, provides an input to filter 515 that indicates whether the most recent V-V interval  $VV_n$  was concluded by an evoked beat initiated by a pacing stimulus delivered by device 105, or was concluded by an intrinsic beat sensed by ventricular sensing circuit 310.

In general terms, if the most recent V-V interval  $VV_n$  is concluded by a 15 sensed/intrinsic beat, then filter 515 provides a new first indicated pacing interval  $T_n$  that is adjusted from the value of the previous first indicated pacing interval  $T_{n-1}$ , such as, for example, decreased by an amount that is based at least partially on the duration of the most recent V-V interval  $VV_n$  and on the duration of the previous value of the first indicated pacing interval  $T_{n-1}$ . If, however, the 20 most recent V-V interval  $VV_n$  is concluded by a paced/evoked beat, then filter 515 provides a new first indicated pacing interval  $T_n$  that is increased from the value of the previous first indicated pacing interval  $T_{n-1}$ , such as, for example, by an amount that is based at least partially on the duration of the most recent V-V interval  $VV_n$  and on the duration of the previous value of the first indicated 25 pacing interval  $T_{n-1}$ . If no ventricular beat is sensed during the new first indicated pacing interval  $T_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse upon the expiration of the new first indicated 30 pacing interval  $T_n$ .

Figure 7 is a signal flow diagram, illustrating generally, by way of example, but not by way of limitation, another conceptualization of operating filter 515, with certain differences from Figure 6 more particularly described

below. In this embodiment, the pacing control module 505, which controls the timing and delivery of pacing pulses, provides an input to filter 515 that indicates whether the most recent V-V interval  $VV_n$  was concluded by an evoked beat initiated by a pacing stimulus delivered by device 105, or was concluded by 5 an intrinsic beat sensed by ventricular sensing circuit 310.

If the most recent V-V interval  $VV_n$  was concluded by an intrinsic beat, then the most recent V-V interval  $VV_n$  and the previous value of the first indicated pacing interval  $T_{n-1}$  are each scaled by respective constants  $A$  and  $B$ , and then summed to obtain the new value of the first indicated pacing interval  $T_n$ , 10 which is stored in register 520 and provided to pacing control module 505.

Alternatively, if the most recent V-V interval  $VV_n$  was concluded by a evoked/paced beat, then the most recent V-V interval  $VV_n$  and the previous value of the first indicated pacing interval  $T_{n-1}$  are each scaled by respective constants 15  $C$  and  $D$ , and then summed to obtain the new value of the first indicated pacing interval  $T_n$ , which is stored in register 520 and provided to pacing control module 505. In one embodiment, the coefficients  $C$  and  $D$  are different from each other, and are either programmable, variable, or constant. In a further embodiment, the coefficient  $C$  is a different value from the coefficient  $A$ , and/or the coefficient  $D$  is a different value than the coefficient  $B$ , and these coefficients are either 20 programmable, variable, or constant. In another embodiment, the coefficient  $D$  is the same value as the coefficient  $B$ .

In one embodiment, operation of filter 515 is described by  $T_n = A \cdot VV_n + B \cdot T_{n-1}$ , if  $VV_n$  is concluded by an intrinsic beat, and is described by  $T_n = C \cdot VV_n + D \cdot T_{n-1}$ , if  $VV_n$  is concluded by a paced beat, where  $A$ ,  $B$ ,  $C$  and  $D$  are coefficients 25 (also referred to as "weights"),  $VV_n$  is the most recent V-V interval duration,  $T_n$  is the new value of the first indicated pacing interval, and  $T_{n-1}$  is the previous value of the first indicated pacing interval. If no ventricular beat is sensed during the new first indicated pacing interval  $T_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , 30 then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse upon the expiration of the new first indicated pacing interval  $T_n$ .

Filter Example 3

In another embodiment, these coefficients can be more particularly described using an intrinsic coefficient ( $a$ ), a paced coefficient ( $b$ ), and a weighting coefficient ( $w$ ). In one such embodiment,  $A = a \cdot w$ ,  $B = (1-w)$ ,  $C = b \cdot w$ ,  
5 and  $D = (1-w)$ . In one example, operation of the filter 515 is described by  $T_n = a \cdot w \cdot VV_n + (1-w) \cdot T_{n-1}$ , if  $VV_n$  is concluded by an intrinsic beat, otherwise is described by  $T_n = b \cdot w \cdot VV_n + (1-w) \cdot T_{n-1}$ , if  $VV_n$  is concluded by a paced beat, as illustrated generally, by way of example, but not by way of limitation, in the signal flow graph of Figure 8. If no ventricular beat is sensed during the new  
10 first indicated pacing interval  $T_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse upon the expiration of the new first indicated  
15 pacing interval  $T_n$ . In one embodiment, the coefficients  $a$  and  $b$  are different from each other, and are either programmable, variable, or constant.

The above-described parameters (e.g.,  $A$ ,  $B$ ,  $C$ ,  $D$ ,  $a$ ,  $b$ ,  $w$ ) are stated in terms of time intervals (e.g.,  $VV_n$ ,  $T_n$ ,  $T_{n-1}$ ). However, an alternate system may produce results in terms of rate, rather than time intervals, without departing from the present method and apparatus. In one embodiment, weighting coefficient  $w$ , intrinsic coefficient  $a$ , and paced coefficient  $b$ , are variables.  
20 Different selections of  $w$ ,  $a$ , and  $b$ , will result in different operation of the present method and apparatus. For example, as  $w$  increases the weighting effect of the most recent V-V interval  $VV_n$  increases and the weighting effect of the previous first indicated pacing rate  $T_{n-1}$  decreases. In one embodiment,  $w = 1/16 = 0.0625$ .  
25 In another embodiment,  $w = 1/32$ . Another possible range for  $w$  is from  $w = 1/2$  to  $w = 1/1024$ . A further possible range for  $w$  is from  $w \approx 0$  to  $w \approx 1$ . Other values of  $w$ , which need not include division by powers of two, may be substituted without departing from the present method and apparatus.

In one embodiment, intrinsic coefficient  $a$ , is selected to be greater than  
30 0.5, or to be greater than 1.0. In one example, the intrinsic coefficient  $a$  is selected to be lesser in value than the pacing coefficient  $b$ . In one example,  $a \approx 1.1$  and  $b \approx 1.2$ . In another embodiment  $a = 0.9$  and  $b = 1.1$ . One possible range

for  $a$  is from  $a = 0.5$  to  $a = 2.0$ , and for  $b$  is from  $b = 1.0$  to  $b = 3.0$ . The coefficients may vary without departing from the present method and apparatus.

In one embodiment, for  $b > 1$  and for substantially regular V-V intervals, filter 515 provides a new first indicated pacing interval  $T_n$  that is at least slightly longer than the expected intrinsic V-V interval being measured by timer 515.

Thus, if the intrinsic V-V interval being timed is consistent with the duration of previously received V-V intervals, then filter 515 avoids triggering a pacing stimulus. In such a case, a pacing pulse is delivered only if the presently timed V-V interval becomes longer than the previous substantially constant V-V intervals. In general terms, filter 515 operates so that pacing pulses are typically inhibited if the ventricular rate is substantially constant. However, if the measured V-V intervals become irregular, then filter 515 operates, over a period of one or several such V-V intervals, to shorten the first indicated pacing interval  $T_n$  so that pacing stimuli are being delivered.

According to one aspect of the invention, it is believed that if the irregular V-V intervals are caused by a conducted atrial tachyarrhythmia, then pacing the ventricle will regularize the ventricular heart rate by establishing retrograde conduction from the ventricle. This, in turn, blocks forward conduction of atrial signals through the atrioventricular (A-V) node. As a result, irregular atrial signals do not trigger resulting irregular ventricular contractions. According to another aspect of the invention, however, this method and apparatus will not introduce pacing pulses until the heartbeat becomes irregular. Therefore, the heart is assured to pace at its intrinsic rate when regular ventricular contractions are sensed.

#### 25                   Controller Example 2

Figure 9 is a schematic diagram illustrating generally, by way of example, but not by way of limitation, another conceptualization of portions of controller 325, with certain differences from Figure 5 more particularly described below. In Figure 9, controller 325 receives from sensor 330 a signal including information from which a physiologically desired heart rate (e.g., based on the patient's activity, respiration, or any other suitable indicator of metabolic need) can be derived. The sensor signal is digitized by an A/D converter 900. The digitized signal is processed by a sensor rate module 905,

which computes a desired heart rate that is expressed in terms of a second indicated pacing interval stored in register 910.

Pacing control module 505 delivers a control signal, which directs ventricular therapy circuit 320 to deliver a pacing pulse, based on either (or both) 5 of the first or second indicated pacing intervals, stored in registers 520 and 910, respectively, or both. In one embodiment, pacing control module 505 includes a selection module 915 that selects between the new first indicated pacing interval  $T_n$  and the sensor-based second indicated pacing interval.

In one embodiment, selection module 915 selects the shorter of the first 10 and second indicated pacing intervals as the selected indicated pacing interval  $S_n$ . If no ventricular beat is sensed during the selected indicated pacing interval  $S_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse 15 upon the expiration of the selected indicated pacing interval  $S_n$ .

In general terms, for this embodiment, the ventricle is paced at the higher 20 of the sensor indicated rate and the VRR indicated rate. If, for example, the patient is resting, such that the sensor indicated rate is lower than the patient's intrinsic rate, and the patient's intrinsic rate is substantially constant, then the intrinsic rate is higher than the VRR indicated rate. As a result, pacing pulses generally will not be delivered. But if, for example, the patient is resting, but with an atrial tachyarrhythmia that induces irregular ventricular contractions, then pacing pulses generally will be delivered at the VRR indicated rate. In another example, if the patient is active, such that the sensor indicated rate is 25 higher than the VRR indicated rate, then pacing pulses generally will be delivered at the sensor indicated rate. In an alternative embodiment, the pacing rate is determined by blending the sensor indicated rate and the VRR indicated rate, rather than by selecting the higher of these two indicated rates (i.e., the shorter of the first and second indicated pacing intervals).

30 In another embodiment, selection module 915 provides a selected indicated pacing interval  $S_n$  based on a blending of both the first and second indicated pacing intervals. In one such example, selection module 915 applies

predetermined or other weights to the first and second indicated pacing intervals to compute the selected pacing interval  $S_n$ .

Controller Example 2

Figure 10 is a schematic diagram illustrating generally, by way of example, but not by way of limitation, another conceptualization of portions of controller 325, with certain differences from Figure 9 more particularly described below. In Figure 10, controller 325 includes an atrial tachyarrhythmia (AT) detection module 1000 that receives a signal from atrial sensing circuit 305. The received signal includes information about atrial events, from which AT detection module 1000 determines the presence or absence of one or more atrial tachyarrhythmias, such as atrial fibrillation.

10 AT detection module 1000 determines the presence or absence of one or more atrial tachyarrhythmias, such as atrial fibrillation.

In one embodiment, AT detection module 1000 provides a control signal, to pacing control module 505, that indicates the presence or absence of an atrial tachyarrhythmia, such as atrial fibrillation. In one embodiment, selection module 915 selects between the first and second indicated pacing intervals as illustrated, by way of example, but not by way of limitation, in Table 1.

Table 1. Example Selection Based on AT Detection, 1st Indicated Pacing Interval, and 2nd Indicated Pacing Interval

20	<i>AT Present?</i>	<i>1st Indicated Pacing Interval &lt; 2nd Indicated Pacing Interval ?</i>	<i>1st Indicated Pacing Interval ≥ 2nd Indicated Pacing Interval ?</i>
	<i>Yes, AT Present</i>	$S_n = 1\text{st Indicated Pacing Interval (i.e., VRR)}$	$S_n = 2\text{nd Indicated Pacing Interval (e.g., Sensor)}$
	<i>No, AT not Present</i>	$S_n = 2\text{nd Indicated Pacing Interval (e.g., Sensor)}$	$S_n = 2\text{nd Indicated Pacing Interval (e.g., Sensor)}$

In this embodiment, if an atrial tachyarrhythmia is present and the first indicated pacing interval is shorter than the second indicated pacing interval, then selection module 915 selects the first indicated pacing interval, which is

based on the VRR techniques described above, as the selected indicated pacing interval  $S_n$ . Otherwise, selection module 915 selects the second indicated pacing interval, which in one embodiment is based on the sensor indications, as the selected indicated pacing interval  $S_n$ . As discussed above, if no ventricular beat 5 is sensed during the selected indicated pacing interval  $S_n$ , which is measured as the time from the occurrence of the ventricular beat concluding the most recent V-V interval  $VV_n$ , then pacing control module 505 instructs ventricular therapy circuit 320 to deliver a ventricular pacing pulse upon the expiration of the selected indicated pacing interval  $S_n$ .

10 Stated differently, for this embodiment, the ventricle is paced at the VRR indicated rate only if an atrial tachyarrhythmia, such as atrial fibrillation, is present and the VRR indicated rate exceeds the sensor indicated rate. Otherwise the ventricle is paced at the sensor indicated rate. If, for example, the patient is resting, such that the sensor indicated rate is lower than the patient's intrinsic 15 rate, and no atrial tachyarrhythmia is present, then the device will sense the intrinsic rate or will deliver ventricular paces at the lower rate limit. But if, for example, the patient is resting, but with an atrial tachyarrhythmia that induces irregular ventricular contractions, then pacing pulses generally will be delivered at the VRR indicated rate. In another example, if the patient is active, such that 20 the sensor indicated rate is higher than the VRR indicated rate, then pacing pulses generally will be delivered at the sensor indicated rate, whether or not atrial tachyarrhythmia is present. As an alternative to the selection described with respect to Table 1, selection module 915 provides a fixed or variable weighting or blending of both the sensor-indicated rate and VRR indicated rate, 25 such that pacing pulses are delivered based on the blended rate.

The second indicated pacing interval need not be based on sensor indications. In one embodiment, for example, the second indicated pacing interval tracks the sensed atrial heart rate when no atrial tachyarrhythmia is present. In this embodiment, selection module 915 performs a mode-switching 30 function in which the first indicated pacing interval is used whenever atrial tachyarrhythmia is present and the second indicated pacing interval (e.g., atrial-tracking) is used when no atrial tachyarrhythmia is present.

In another embodiment, heart rate/interval is used as a trigger turn on/off use of the first indicated pacing interval (e.g., the VRR indicated pacing interval). In one example, pacing therapy is based on the first indicated pacing interval if the first indicated pacing interval is longer than a first predetermined value, and pacing therapy is substantially independent of the first indicated 5 pacing interval if the first indicated pacing interval is shorter than the first predetermined value. In this example, the VRR indicated pacing interval is used at low heart rates, but not at fast heart rates.

Filter Rate Behavior Example 1

10 Figure 11 is a graph illustrating generally, by way of example, but not by way of limitation, one embodiment of a VRR indicated rate for successive ventricular heart beats for one mode of operating filter 515. As discussed above, the VRR indicated rate is simply the frequency, between ventricular heart beats, associated with the first indicated pacing interval. Stated differently, the VRR 15 indicated rate is the inverse of the duration of the first indicated pacing interval. If pacing is based solely on the VRR indicated rate, pacing control module 505 directs ventricular therapy circuit 320 to issue a pacing pulse after the time since the last ventricular beat equals or exceeds the first indicated pacing interval. However, as described above, in certain embodiments, pacing control module 20 505 directs ventricular therapy circuit 320 to issue a pacing pulse based on factors other than the VRR indicated rate such as for, example, based on the sensor indicated rate.

In the example illustrated in Figure 11, a first sensed intrinsic ventricular beat, indicated by an "S" was detected just before expiration of the first indicated 25 pacing interval ("VRR indicated pacing interval")  $T_o$ , as computed based on a previous ventricular beat. In one embodiment, the new VRR indicated pacing interval  $T_i$  is computed based on the duration of most recent V-V interval  $IV$ , and a previous value of the VRR indicated pacing interval  $T_o$ , as discussed above. In this example, the new VRR indicated pacing interval  $T_i$  corresponds 30 to a lower rate limit (LRL) time interval. In one embodiment, the allowable range of the VRR indicated pacing interval is limited so that the VRR indicated pacing interval does not exceed the duration of the LRL time interval, and so that

the VRR indicated pacing interval is not shorter than the duration of an upper rate limit (URL) time interval.

The second ventricular beat is also sensed, just before expiration of the VRR indicated pacing interval  $T_1$ . In one embodiment, the new VRR indicated 5 pacing interval  $T_2$  is computed based on the duration of most recent V-V interval  $VV_2$ , and a previous value of the VRR indicated pacing interval,  $T_1$ , as discussed above. The first and second ventricular beats represent a stable intrinsic rhythm, for which no pacing is delivered because the VRR indicated pacing interval is at a lower rate than the sensed intrinsic ventricular beats.

10 The third, fourth, and fifth ventricular beats represent the onset of atrial fibrillation, resulting in erratic ventricular rates. The third ventricular beat is sensed well before expiration of the VRR indicated pacing interval  $T_2$ , such that no pacing pulse is issued. For the sensed third ventricular beat, filter 515 computes the new VRR indicated pacing interval  $T_3$  as being shorter in duration 15 relative to the previous VRR indicated pacing interval  $T_2$ .

18 The fourth ventricular beat is similarly sensed well before expiration of the VRR indicated pacing interval  $T_3$ , such that no pacing pulse is issued. For the sensed fourth ventricular beat, filter 515 computes the new VRR indicated pacing interval  $T_4$  as being shorter in duration relative to the previous VRR indicated pacing interval  $T_3$ ,

22 The fifth ventricular beat is sensed before expiration of the VRR indicated pacing interval  $T_4$ , such that no pacing pulse is issued. For the sensed fifth ventricular beat, filter 515 computes the new VRR indicated pacing interval  $T_5$  as being shorter in duration relative to the previous VRR indicated pacing 25 interval  $T_4$ .

28 The sixth, seventh, and eighth ventricular beats indicate regularization of the ventricular rate using the pacing techniques described above. No ventricular beat is sensed during the VRR indicated pacing interval  $T_5$ , so a pacing pulse is issued to evoke the sixth ventricular beat. A new VRR indicated pacing interval 30  $T_6$  is computed as being increased in duration relative to the previous VRR indicated pacing interval  $T_5$ , lowering the VRR indicated rate. Similarly, no ventricular beat is sensed during the VRR indicated pacing interval.

The ninth ventricular beat represents another erratic ventricular beat resulting from the atrial fibrillation episode. The ninth ventricular beat is sensed before expiration of the VRR indicated pacing interval  $T_8$ . As a result, a shorter new VRR indicated pacing interval  $T_9$  is computed.

5       The tenth and eleventh ventricular beats illustrate further regularization of the ventricular rate using the pacing techniques described above. No ventricular beat is sensed during the VRR indicated pacing interval  $T_9$ , so a pacing pulse is issued to evoke the tenth ventricular beat. A new VRR indicated pacing interval  $T_{10}$  is computed as being increased in duration relative to the previous VRR indicated pacing interval  $T_9$ , lowering the VRR indicated rate.

10      Similarly, no ventricular beat is sensed during the VRR indicated pacing interval  $T_{10}$ , so a pacing pulse is issued to evoke the tenth ventricular beat. A new VRR indicated pacing interval  $T_{11}$  is compute as being increased in duration relative to the previous VRR indicated pacing interval  $T_{10}$ , lowering the VRR indicated rate.

15      The twelfth, thirteenth, fourteenth, and fifteenth ventricular beats illustrate resumption of a stable intrinsic rhythm after termination of the atrial fibrillation episode. For such a stable rate, the VRR indicated rate proceeds asymptotically toward a “floor value” that tracks, but remains below, the intrinsic rate. This allows the intrinsic heart signals to control heart rate when such intrinsic heart signals provide a stable rhythm. As a result, when the patient’s intrinsic rate is constant, paces will be withheld, allowing the patient’s intrinsic heart rhythm to continue. If the patient’s heart rate includes some variability, and the VRR indicated floor value is close to the mean intrinsic heart rate, then occasional paced beats will occur. Such pace beats will gradually

20      lengthen the VRR indicated pacing interval, thereby allowing subsequent intrinsic behavior when the patient’s heart rate becomes substantially constant.

25

The intrinsic coefficient  $a$  of filter 515 controls the “attack slope” of the VRR indicated heart rate as the VRR indicated heart rate increases because of sensed intrinsic beats. The paced coefficient  $b$  of filter 515 controls the “decay slope” of the VRR indicated heart rate as the VRR indicated heart rate decreases during periods of paced beats. In one embodiment, in which  $a > 1.0$  and  $b > 1.0$ , decreasing the value of  $a$  toward 1.0 increases the attack slope such that the VRR indicated rate increases faster in response to sensed intrinsic beats, while

decreasing the value of  $b$  toward 1.0 decreases the decay slope such that the VRR indicated rate decreases more slowly during periods of paced beats. Conversely, for  $a > 1.0$  and  $b > 1.0$ , increasing the value of  $a$  from 1.0 decreases the attack slope such that the VRR indicated rate increases more slowly in 5 response to sensed intrinsic beats, while increasing the value of  $b$  from 1.0 increases the decay slope such that the VRR-indicated rate decreases more quickly during periods of paced beats.

In one embodiment, for  $a > 1.0$  and  $b > 1.0$ , decreasing both  $a$  and  $b$  toward 1.0 increases VRR indicated rate during periods of sensed intrinsic 10 activity so that the VRR indicated rate is closer to the mean intrinsic rate. Because the VRR indicated rate is closer to the mean intrinsic rate, variability in the intrinsic heart rate is more likely to trigger paces at the VRR indicated rate. On the other hand, for  $a > 1.0$  and  $b > 1.0$ , increasing both  $a$  and  $b$  from 1.0 15 decreases the VRR indicated rate during periods of sensed intrinsic activity so that the VRR indicated rate is farther beneath the mean intrinsic rate. Because the VRR indicated rate is farther beneath the mean intrinsic rate, the same variability in the intrinsic heart rate becomes less likely to trigger paces at the VRR indicated rate.

In one embodiment, these coefficients are programmable by the user, 20 such as by using remote programmer 125. In another embodiment, the user selects a desired performance parameter (e.g., desired degree of rate regularization, desired attack slope, desired decay slope, etc.) from a corresponding range of possible values, and device 105 automatically selects the appropriate combination of coefficients of filter 515 to provide a filter setting 25 that corresponds to the selected user-programmed performance parameter, as illustrated generally by Table 2. Other levels of programmability or different combinations of coefficients may also be used.

**Table 2. Example of Automatic Selection of Aspects of Filter Setting Based on a User-Programmable Performance Parameter.**

User-Programmable Performance Parameter	Intrinsic Coefficient <i>a</i>	Paced Coefficient <i>b</i>
1 (Less Rate Regularization)	2.0	3.0
2	1.8	2.6
3	1.6	2.2
4	1.4	1.8
5	1.2	1.4
6 (More Rate Regularization)	1.0	1.0

15

#### Filter Rate Behavior Example 2

Figure 12 is a graph illustrating generally, by way of example, but not by way of limitation, one embodiment of selecting between more than one indicated pacing interval. Figure 12 is similar to Figure 11 in some respects, but Figure 12 includes a second indicated pacing interval. In one embodiment, the first indicated pacing interval is the VRR indicated pacing interval, described above, and the second indicated pacing interval is a sensor indicated pacing interval, from an accelerometer, minute ventilation, or other indication of the patient's physiological need for increased cardiac output.

In one embodiment, a selected indicated pacing interval is based on the shorter of the first and second indicated pacing intervals. Stated differently, device 105 provides pacing pulses at the higher indicated pacing rate. In the example illustrated in Figure 12, first and second beats and the twelfth through fifteenth beats are paced at the sensor indicated rate, because it is higher than the VRR indicated rate and the intrinsic rate. The third, fourth, fifth, and ninth beats are sensed intrinsic beats that are sensed during the shorter of either of the VRR and sensor indicated pacing intervals. The sixth through eighth beats and ninth and tenth beats are paced at the VRR indicated rate, because it is higher than the

sensor indicated rate. Also, for these beats, no intrinsic beats are sensed during the VRR indicated intervals. In this embodiment, the ranges of both the sensor indicated rate and the VRR indicated rate are limited so that they do not extend to rates higher than the URL or to rates lower than the LRL. In one embodiment, 5 the LRL and the URL are programmable by the user, such as by using remote programmer 125.

In a further embodiment, the selected indicated pacing interval is based on the shorter of the first and second indicated pacing intervals only if an atrial tachyarrhythmia, such as atrial fibrillation, is present. Otherwise, the second 10 indicated pacing interval is used, as described above.

#### Filter Rate Behavior Example 3

Figure 13 is a graph illustrating generally, by way of example, but not by way of limitation, another illustrative example of heart rate vs. time according to a spreadsheet simulation of the behavior of the above-described VRR algorithm. 15 In Figure 13, the VRR algorithm is turned off until time 130. Stable intrinsic lower rate behavior is modeled for times between 0 and 10 seconds. Erratic intrinsic ventricular rates, such as would result from atrial tachyarrhythmias including atrial fibrillation, are modeled during times between 10 seconds and 130 seconds. At time 130 seconds, the VRR algorithm is turned on. While 20 some erratic intrinsic beats are subsequently observed, the VRR algorithm provides pacing that is expected to substantially stabilize the heart rate, as illustrated in Figure 13. The VRR indicated pacing rate gradually decreases until intrinsic beats are sensed, which results in a slight increase in the VRR indicated pacing rate. Thus, the VRR algorithm favors the patient's intrinsic heart rate 25 when it is stable, and paces at the VRR indicated heart rate when the patient's intrinsic heart rate is unstable. It is noted that Figure 13 does not represent clinical data, but rather provides a simulation model that illustrates one example of how the VRR algorithm is expected to operate.

#### Filter Example 4

30 In one embodiment, filter 515 includes variable coefficients such as, for example, coefficients that are a function of heart rate (or its corresponding time interval). In one example, operation of the filter 515 is described by  $T_n = a \cdot w \cdot VV_n + (1-w) \cdot T_{n-1}$ , if  $VV_n$  is concluded by an intrinsic beat, otherwise is

described by  $T_n = b \cdot w \cdot VV_n + (1-w) \cdot T_{n-1}$ , if  $VV_n$  is concluded by a paced beat, where at least one of  $a$  and  $b$  are linear, piecewise linear, or nonlinear functions of one or more previous V-V intervals such as, for example, the most recent V-V interval,  $VV_n$ .

5       Figure 14 is a graph illustrating generally, by way of example, but not by way of limitation, one embodiment of using at least one of coefficients  $a$  and  $b$  as a function of one or more previous V-V intervals such as, for example, the most recent V-V interval,  $VV_n$ . In one such example,  $a$  is less than 1.0 when  $VV_n$  is at or near the lower rate limit (e.g., 1000 millisecond interval or 60

10      beats/minute), and  $a$  is greater than 1.0 when  $VV_n$  is at or near the upper rate limit (e.g., 500 millisecond interval or 120 beats/minute). For a constant  $b$ , using a smaller value of  $a$  at lower rates will increase the pacing rate more quickly for sensed events; using a larger value of  $a$  at higher rates increases the pacing rate more slowly for sensed events. In another example,  $b$  is close to 1.0 when  $VV_n$  is

15      at or near the lower rate limit, and  $b$  is greater than 1.0 when  $VV_n$  is at or near the upper rate limit. For a constant  $a$ , using a smaller value of  $b$  at lower rates will decrease the pacing rate more slowly for paced events; using a larger value of  $b$  at higher rates decreases the pacing rate more quickly for paced events.

20       USING VRR FOR OPTIMIZING TIMING OF ATRIAL  
                CARDIOVERSION/DEFIBRILLATION THERAPY

Figure 15 is a schematic diagram, similar to Figure 2, illustrating generally, by way of example, but not by way of limitation, another embodiment of portions of system 100 and an environment in which it is used. In this embodiment, atrial lead 110A includes electrodes disposed in, around, or near right atrium 200A of heart 115, such as superior vena cava (SVC) ring electrode 1500 and coronary sinus (CS) ring electrode 1505 for delivering cardioversion/defibrillation therapy to right atrium 200A. Atrial lead 110A may also include additional electrodes, such as for sensing intrinsic heart signals and for delivering atrial or ventricular pacing or cardioversion/defibrillation therapy to heart 115. Alternatively, electrodes for sensing intrinsic atrial heart signals and delivering atrial pacing therapy are included on a separate lead disposed in right atrium 200A, as illustrated in Figure 2. Moreover, additional electrodes may be located elsewhere, for sensing or delivering pacing or

cardioversion/defibrillation therapy, such as using a portion of the can of hermetically sealed device 105 or using an electrode at a header portion extending therefrom.

Figure 16 is a schematic diagram, similar to Figure 3, illustrating generally, by way of example, but not by way of limitation, another embodiment of portions of device 105, which is coupled to heart 115. In this embodiment, device 105 includes an atrial therapy circuit 1600 providing atrial cardioversion/defibrillation therapy, as appropriate, to electrodes located at or near one of the atria 200 of heart 115, for terminating atrial fibrillation or other atrial tachyarrhythmias. In one embodiment, atrial therapy circuit 1600 also provides atrial pacing therapy to electrodes located at or near one of the atria 200 of heart 115 for obtaining resulting evoked atrial depolarizations, i.e., paced atrial beats.

Controller 325 controls the delivery of therapy, by atrial therapy circuit 1600 and ventricular therapy circuit 320, based on heart activity signals received from atrial sensing circuit 305 and ventricular sensing circuit 310, as discussed below. Controller 325 includes various modules, which are implemented either in hardware or as one or more sequences of steps carried out on a microprocessor or other microcontroller. Though such modules are illustrated separately for conceptual clarity, it is understood that the various modules of controller 325 need not be separately embodied, but may be combined or otherwise implemented differently, such as in software/firmware.

In one embodiment, controller 325 includes a V-V interval timer 510, for measuring time intervals ("V-V intervals") between successive ventricular depolarizations obtained from ventricular event module 500. The V-V intervals are provided to VRR module 1605, which performs the ventricular rate regularization techniques described above with respect to Figures 5-14. In one embodiment, detection of an atrial tachyarrhythmia by atrial sensing circuit 305 triggers the regularization of the ventricular rate using VRR techniques. In another embodiment, however, VRR techniques are used even when no atrial tachyarrhythmia is present. V-V interval timer 510 also provides the V-V intervals to atrial cardioversion/defibrillation control module 1610, which evaluates the V-V intervals based on certain criteria to determine whether

potentially proarrhythmic heart conditions exist. If such potentially proarrhythmic heart conditions exist, atrial cardioversion/defibrillation module 1610 withholds atrial cardioversion/defibrillation therapy until VRR module 1605 suitably stabilizes the ventricular heart rate using the VRR techniques.

5       Example Method of Operating Cardiac Rhythm Management Device

The present system recognizes that atrial tachyarrhythmias typically cause significant variability in the ventricular heart rate. Device 105 avoids delivering atrial cardioversion/defibrillation therapy during such irregular ventricular heart activity, because such conditions may be potentially 10 proarrhythmic, such that delivering atrial cardioversion/defibrillation therapy could result in dangerous ventricular arrhythmias. Using the VRR techniques described above, device 105 stabilizes the ventricular heart rate to obtain less potentially proarrhythmic conditions for delivering the atrial tachyarrhythmia therapy as a result of the more regular ventricular heart rate. Device 105 15 withholds delivery of atrial cardioversion/defibrillation therapy until the V-V intervals meet certain criteria that indicate a decreased chance that the atrial cardioversion/defibrillation therapy will induce a ventricular arrhythmia.

Figure 17 is a flow chart illustrating generally, by way of example, but not by way of limitation, one embodiment of operating device 105 for delivering 20 atrial cardioversion/defibrillation therapy to terminate an atrial tachyarrhythmia, such as atrial fibrillation, and enable the resumption of normal atrial heart rhythms.

At step 1700, atrial sensing circuit 305 is used to detect an atrial tachyarrhythmia, such as atrial fibrillation. If atrial fibrillation is detected at step 25 1700, then step 1705 initiates stabilization of the ventricular heart rate, using the VRR techniques discussed above, in order to obtain conditions that are not potentially proarrhythmic. (As described above, in one embodiment, VRR stabilization techniques provide pacing that overdrives the intrinsic ventricular heart rate unless the intrinsic ventricular heart rate is substantially regular). If 30 atrial fibrillation is not detected at step 1700, then at step 1710, a conventional pacing algorithm is used to determine whether pacing therapy should be delivered to the heart 115.

Step 1715 performs a beat-by-beat determination of whether potentially proarrhythmic conditions exist in the ventricle, based on the V-V time interval between paced or sensed ventricular events. One embodiment of performing step 1715 is described more particularly below with respect to Figure 18. If step 5 1715 indicates that no potentially proarrhythmic conditions exist, then atrial cardioversion/defibrillation therapy is delivered in step 1720. Otherwise, potentially proarrhythmic conditions do exist, and such atrial-cardioversion/defibrillation therapy is withheld (i.e., step 1720 is bypassed) until no potentially proarrhythmic conditions exist, with stabilization of the 10 ventricular heart rate using VRR continuing at step 1705. Stabilization of the ventricular heart rate, at step 1705, more quickly obtains conditions that are not potentially proarrhythmic, because the VRR techniques promote ventricular pacing at a rate that is close to the mean intrinsic ventricular heart rate during periods of erratic intrinsic ventricular heart rates. This, in turn, stabilizes the 15 ventricular heart rate, as described above, more quickly obtaining conditions that are not potentially proarrhythmic.

In one embodiment, delivery of the atrial cardioversion/defibrillation therapy at step 1720 is synchronized to the most recent ventricular beat, i.e., the ventricular beat that concludes  $VV_n$ . In one example, if the most recent 20 ventricular beat is a paced beat, then, at step 1720, a defibrillation countershock is delivered to the right atrium 200A within approximately 20 to 150 milliseconds (e.g., 70 milliseconds) after the pacing pulse was delivered. In this same example, if the most recent ventricular beat is a sensed beat, then, at step 1720, a defibrillation countershock is delivered to the right atrium 200A during 25 the QRS complex of the sensed ventricular beat. In one embodiment, an atrial defibrillation countershock of approximately between 1 Joule and 25 Joules (e.g., approximately 4 Joules) is delivered between electrode 1505 located in or near coronary sinus 220 and an electrode 1500 located in a supraventricular region such as in or near the superior vena cava. In another embodiment, the 30 atrial defibrillation countershock is delivered between an electrode 1505 located in or near coronary sinus 220 and a pair of intercoupled electrodes located (1) in or near coronary sinus 220 and (2) at device 105 or header 225.

By stabilizing the ventricular heart rate before delivering atrial cardioversion/defibrillation therapy, device 105 promotes conditions that not potentially proarrhythmic, such that atrial cardioversion/defibrillation therapy can be safely delivered at step 1720. Thus, device 105 advantageously actively

5 stabilizes the heart to obtain conditions that are not potentially proarrhythmic, and does so more quickly than if the heart were not actively stabilized. The stabilization is performed using the VRR techniques described above. In one embodiment, the VRR techniques stabilize the ventricular rate at a variable rate that is based at least in part on the patient's underlying intrinsic rate; the VRR

10 indicated rate is based on either intrinsic or evoked ventricular activations, or both.

Because the ventricular rate stabilization is based on the patient's underlying intrinsic ventricular rate, as determined using the VRR techniques described above, device 105 ensures that the ventricular pacing rate will be high enough to stabilize the ventricular heart rate during periods of erratic intrinsic ventricular activity. Moreover, because the ventricular pacing rate is based on the intrinsic ventricular rate, the patient need not be paced at excessive ventricular rates when stabilizing intrinsic ventricular heart activity.

Figure 18 is a flow chart that illustrates generally, by way of example, but not by way of limitation, one embodiment of determining whether potentially proarrhythmic conditions exist at step 1715 of Figure 17. Figure 18 illustrates one embodiment of a sequence of substeps underlying decision block 1715 in Figure 17. In Figure 18, at step 1800, the most recent V-V interval,  $VV_n$ , is compared to a first predetermined value,  $T_1$ . At step 1805, if  $VV_n$  is greater than  $T_1$  (or, in an alternate embodiment, greater than or equal to  $T_1$ ), then at step 1810 the algorithm deems that no potentially proarrhythmic conditions exist. Otherwise, at step 1815,  $VV_n$  is compared to a third predetermined value,  $T_3$ . At step 1820, if  $VV_n$  is less than  $T_3$  (or, in an alternate embodiment, less than or equal to  $T_3$ ), then at step 1825 the algorithm deems that potentially proarrhythmic conditions do exist. Otherwise, at step 1830 the most recent V-V interval,  $VV_n$ , is compared to the previous V-V interval,  $VV_{n-1}$ . At step 1835, if the difference between  $VV_n$  and  $VV_{n-1}$  is less than a second predetermined value,  $T_2$  (or, in an alternate embodiment, less than or equal to  $T_2$ ), then at step 1840 the

algorithm deems that no potentially proarrhythmic conditions exist. Otherwise, at step 1845, the algorithm deems that potentially proarrhythmic conditions do exist.

Figure 19 is a chart that illustrates generally, by way of example, but not by way of limitation, one embodiment of determining whether potentially proarrhythmic conditions exist, such as described with respect to Figure 18. In Figure 19, the Y-axis indicates increasing ventricular heart rate in a first direction, and increasing V-V interval duration in a second direction opposite to the first, as a result of the inverse relationship between rate and interval. In Zone 1, if the most recent V-V interval,  $VV_n$ , is longer than (or alternatively, longer than or equal to)  $T_1$  (e.g.,  $T_1 = 800$  milliseconds), then the algorithm deems that no potentially proarrhythmic conditions exist in the ventricle. In Zone 2, if the most recent V-V interval,  $VV_n$ , is shorter than (or alternatively, shorter than or equal to)  $T_3$  (e.g.,  $T_3 = 500$  milliseconds), then the algorithm deems that potentially proarrhythmic conditions do exist in the ventricle. In Zone 3, for  $VV_n$  between  $T_1$  and  $T_3$  (or alternatively, within such range including the endpoints  $T_1$  and  $T_3$ ), then a further comparison is made between the most recent V-V interval,  $VV_n$ , and the previous V-V interval,  $VV_{n-1}$ . If the magnitude of the difference between  $VV_n$  and  $VV_{n-1}$  is less than  $T_2$  (or alternatively, less than or equal to  $T_2$ ), then the algorithm deems that potentially proarrhythmic conditions do not exist (condition "B"); otherwise, the algorithm deems that potentially proarrhythmic conditions do exist (condition "A"). When the ventricular heart rate is in Zone 3, use of the VRR techniques in step 1705 of Figure 17 promotes condition B over condition A, because VRR stabilizes the ventricular heart rate, thereby reducing the time differences between successive V-V intervals. Thus, stabilization of the ventricular heart rate using the VRR techniques promotes conditions that are not potentially proarrhythmic, so that atrial cardioversion/defibrillation therapy can be delivered quickly, but also safely, i.e., without risking inducing a ventricular tachyarrhythmia. Moreover, stabilization of the ventricular heart rate using VRR techniques quickly obtains a regular ventricular heart rhythm because, as explained above, the VRR stabilization is based on the underlying intrinsic heart rate and, in one embodiment, uses an IIR

filter than establishes a VRR-indicated rate based on the most recent V-V interval,  $VV_n$ , and a previous value of the VRR-indicated rate.

In one embodiment,  $T_1$  is programmable to values approximately between 700 milliseconds and 1000 milliseconds, with a default value of 5 approximately 800 milliseconds. In this embodiment,  $T_3$  is programmable to values that are less than (or, alternatively, less than or equal to)  $T_1$  and in the range approximately between 350 milliseconds and 1000 milliseconds, with  $T_3$  having a default value of approximately 500 milliseconds. Also in this embodiment,  $T_2$  is programmable to values that are approximately between 0 10 milliseconds and 200 milliseconds, with  $T_2$  having a default value of approximately 90 milliseconds. The values of these time intervals are illustrative only, and not intended to be restrictive.

Figure 20 is a flow chart, similar to Figure 17, illustrating generally, by way of example, but not by way of limitation, an embodiment of operating device 105 in which stabilization of the ventricular heart rate using the VRR algorithm is independent of whether atrial tachyarrhythmias are detected. At step 2000, pacing therapy is delivered to the ventricle at the VRR-indicated rate (either alone, or in combination with a sensor-indicated rate, as described above) even if no atrial tachyarrhythmia is present. At step 1700, if an atrial tachyarrhythmia (AT) such as atrial fibrillation is detected, and no potentially proarrhythmic conditions exist at step 1715, then device 105 provides atrial cardioversion/defibrillation therapy at step 1720. If no atrial tachyarrhythmia is detected at step 1700 or if potentially proarrhythmic conditions exist at step 1715, then device 105 withholds atrial cardioversion/defibrillation therapy (i.e., 20 step 1720 is bypassed) and continues to provide pacing at the VRR-indicated rate at step 2000. As a result, atrial cardioversion/defibrillation therapy is only delivered at step 1720 if the atrial tachyarrhythmia exists in the absence of potentially proarrhythmic conditions. By using the VRR pacing algorithm in step 2000, the ventricular heart rate is stabilized to obtain conditions that are not 25 potentially proarrhythmic so that atrial cardioversion/defibrillation therapy is delivered quickly and safely. In summary, while Figure 17 illustrates using VRR only when an atrial tachyarrhythmia is detected (also referred to as “fallback to VRR” initiated by AT), Figure 20 illustrates using VRR to 30

determine the indicated ventricular heart rate even when atrial tachyarrhythmias are not present.

Figure 21 is a flow chart, similar to Figure 18, illustrating generally, by way of example, but not by way of limitation, an embodiment of operating device 105 in which one or more of the predetermined values to which V-V intervals are compared is different if  $VV_n$  is initiated by a paced ventricular beat than if  $VV_n$  is initiated by a sensed ventricular beat, as determined in step 2100. In one embodiment, the algorithm uses a longer first predetermined value  $T_{1B}$  when  $VV_n$  is initiated by a paced beat than the corresponding first predetermined value  $T_{1A}$  when  $VV_n$  is initiated by a sensed beat. This is because a paced beat is followed by a refractory period during which time the ventricular sensing circuit is disconnected from ventricular lead 110B to avoid saturating the ventricular sense amplifier circuits as a result of the afterpotentials produced by delivering a pacing pulse. Because device 105 is "blind" to ventricular depolarizations occurring during the post-pace refractory period, the most recent V-V interval, if  $VV_n$  is initiated by a paced ventricular beat, it is compared to a first predetermined value  $T_{1B}$  that is longer than the first predetermined value  $T_{1A}$  corresponding to a most recent V-V interval,  $VV_n$  initiated by a sensed ventricular beat. Similarly, in one embodiment, the third predetermined value  $T_{3B}$  is longer when  $VV_n$  is initiated by a paced beat than the third predetermined value  $T_{3A}$  when  $VV_n$  is initiated by a sensed beat. This accounts for the additional time during which device 105 is "blind" following a paced ventricular beat. Similarly, in another embodiment, the second predetermined value  $T_{2B}$  is longer when  $VV_n$  is initiated by a paced beat than the second predetermined value  $T_{2A}$  when  $VV_n$  is initiated by a sensed beat.

#### Conclusion

The above-described system provides, among other things, atrial shock timing optimization. The system detects an atrial tachyarrhythmia, such as atrial fibrillation. Such atrial tachyarrhythmias typically cause significant variability in the ventricular heart rate. The system avoids delivering atrial cardioversion/defibrillation therapy during such irregular ventricular heart activity, because such conditions may be potentially proarrhythmic, such that delivering atrial cardioversion/defibrillation therapy could result in dangerous

ventricular arrhythmias. Using Ventricular Rate Regularization (“VRR”) techniques described above, the system stabilizes the ventricular heart rate to obtain less potentially proarrhythmic conditions for delivering the atrial tachyarrhythmia therapy. The system withholds delivery of atrial

5 cardioversion/defibrillation therapy until the intervals between ventricular beats (“V-V intervals”) meet certain criteria that decrease the chance that the atrial cardioversion/defibrillation therapy will induce a ventricular arrhythmia.

It is to be understood that the above description is intended to be illustrative, and not restrictive. Many other embodiments will be apparent to 10 those of skill in the art upon reviewing the above description. The scope of the invention should, therefore, be determined with reference to the appended claims, along with the full scope of equivalents to which such claims are entitled.

WHAT IS CLAIMED IS:

1. A system, comprising:
  - a first signal sensing circuit;
  - 5 a second signal sensing circuit;
  - a first therapy circuit;
  - an second therapy circuit; and
  - a controller that includes:
    - a stabilization module that stabilizes a rate with the first therapy
    - 10 circuit at a variable indicated rate based on an underlying intrinsic rate as sensed in the second signal sensing circuit; and
    - an control module that (a) determines if first types of conditions exist based on intervals between events sensed by the second signal sensing circuit, and (b) delivers a control signal to the second therapy
    - 15 circuit when no first types of conditions exist, and otherwise withholds the delivery of the control signal.
2. The system of claim 1, where the control module compares a most recent interval to a first predetermined value, and deems no first types of conditions exit
- 20 if the most recent interval is one of (1) longer than a first predetermined value, or (2) longer than or equal to the first predetermined value.
3. The system of claim 2, in which the first predetermined value is approximately between 700 milliseconds and 1000 milliseconds.
- 25 4. The system of claims 2 and 3, in which the first predetermined value is programmable.
5. The system of claim 2, in which the first predetermined value is
- 30 approximately equal to 800 milliseconds.

6. The system of claim 2, in which the first predetermined value is different when the most recent interval is initiated by a sensed beat than when the most recent interval is initiated by a paced beat.
- 5 7. The system of claim 2, where the control module deems that no first types of conditions exist if the most recent interval is shorter than the first predetermined value and the most recent interval is not shorter than a previous interval by more than a second predetermined value.
- 10 8. The system of claim 7, in which the second predetermined value is approximately between 0 milliseconds and 200 milliseconds.
9. The system of claim 7, in which the second predetermined value is programmable.
- 15 10. The system of claim 7, in which the second predetermined value is approximately equal to 90 milliseconds.
11. The system of claim 7, in which the second predetermined value is
- 20 different when the most recent interval is initiated by a sensed beat than when the most recent interval is initiated by a paced beat.
12. The system of claims 2 and 7, where the control module deems the first types of conditions to exist if the most recent interval is one of (1) shorter than a
- 25 third predetermined value, or (2) shorter than or equal to the third predetermined value.
13. The system of claim 12, in which the third predetermined value is different when the most recent interval is initiated by a sensed beat than when
- 30 the most recent interval is initiated by a paced beat.
14. The system of claim 12, in which the third predetermined value approximately between 350 milliseconds and 1000 milliseconds, and the third

predetermined value is one of: (1) less than the first predetermined value, or (2) less than or equal to the first predetermined value.

15. The system of claim 12, in which the third predetermined value is  
5 programmable.

16. The system of claim 12, in which the third predetermined value is  
approximately equal to 500 milliseconds.

10 17. The system of claim 1, where the stabilization module obtains intervals  
between beats, computes a first indicated interval based on at least a most recent  
interval duration and a previous value of the first indicated interval, and where  
the control module delivers the control signal based on the first indicated  
interval.

15  
18. The system of claim 1, where the system is a cardiac rhythm  
management system, the first signal sensing circuit is an atrial heart signal  
sensing circuit, the second signal sensing circuit is a ventricular heart signal  
sensing circuit, the first therapy circuit is a ventricular pacing therapy circuit, the  
20 second therapy circuit is an atrial cardioversion/defibrillation therapy circuit, the  
stabilization module is a ventricular rate stabilization module, the rate is a  
ventricular heart rate, the underlying intrinsic rate is an underlying intrinsic  
ventricular heart rate, the control module is an atrial cardioversion/defibrillation  
control module, the first types of conditions are potentially proarrhythmic  
25 conditions, the intervals are V-V intervals, the events are ventricular events, and  
the control signal causes the delivery of cardioversion/defibrillation therapy to  
the atrium when no potentially proarrhythmic conditions exist, and otherwise  
withholds the delivery of cardioversion/defibrillation therapy to the atrium.

30 19. A method comprising:  
detecting an episode;  
stabilizing a rate at a variable indicated rate based on an underlying  
intrinsic rate;

determining if first types of conditions exist based on intervals between events; and

providing a control signal when first types of conditions do not exist, otherwise withholding the control signal until the first types of conditions do not exist.

20. The method of claim 19, where determining if first types of conditions exist include:

comparing a most recent interval to a first predetermined value; and

10 deeming no first types of conditions exist if the most recent interval is one of (1) longer than a first predetermined value, or (2) longer than or equal to the first predetermined value.

21. The method of claim 20, in which the first predetermined value is different when the most recent interval is initiated by a sensed beat than when the most recent interval is initiated by a paced beat.

22. The method of claim 20, including deeming that no first types of conditions exist if the most recent interval is shorter than the first predetermined value and the most recent interval is not shorter than a previous interval by more than a second predetermined value.

23. The method of claim 22, in which the second predetermined value is different when the most recent interval is initiated by a sensed beat than when the most recent interval is initiated by a paced beat.

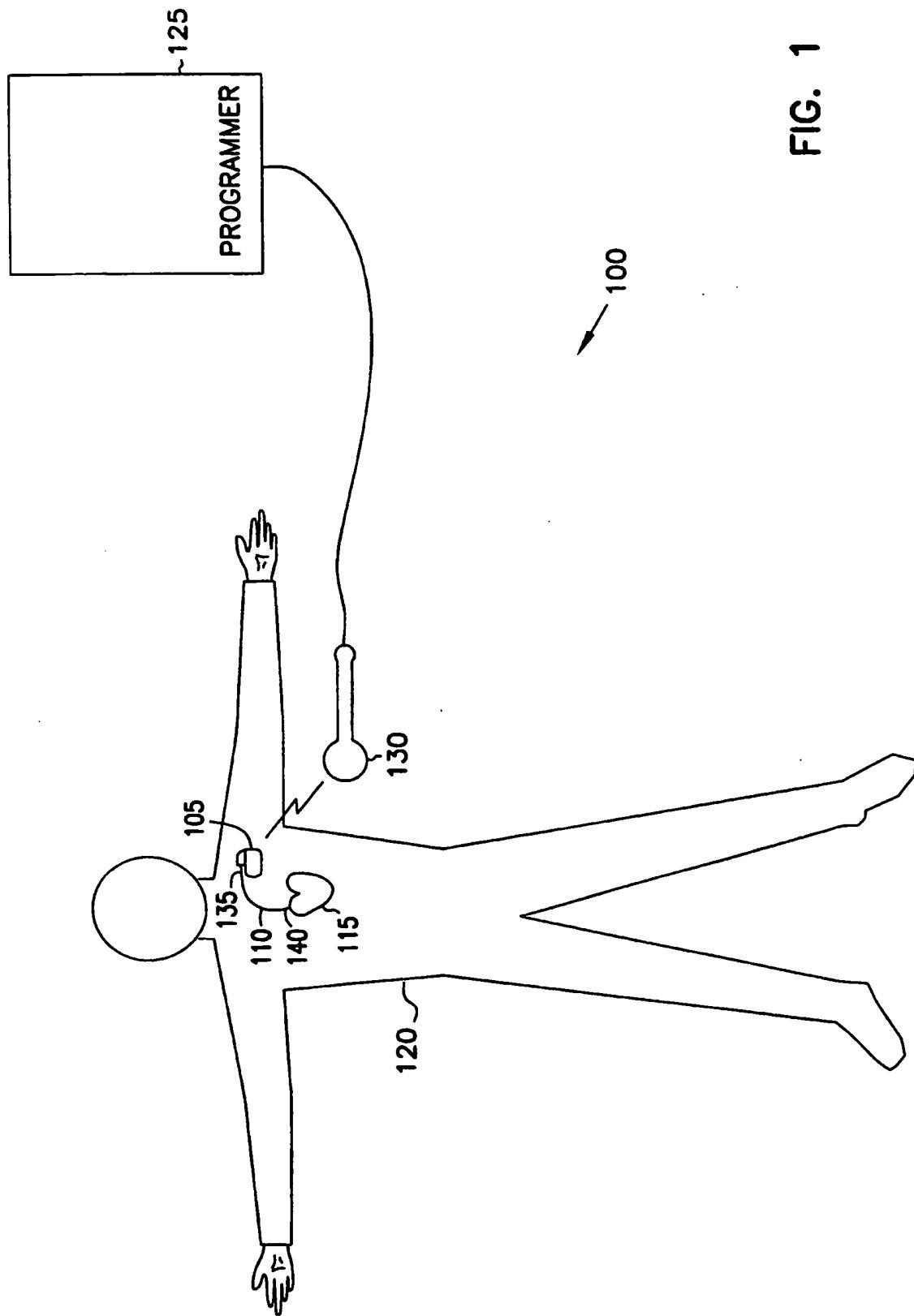
24. The method of claims 20 and 22, including deeming first types of conditions exist if the most recent interval is one of (1) shorter than a third predetermined value, or (2) shorter than or equal to the third predetermined value.

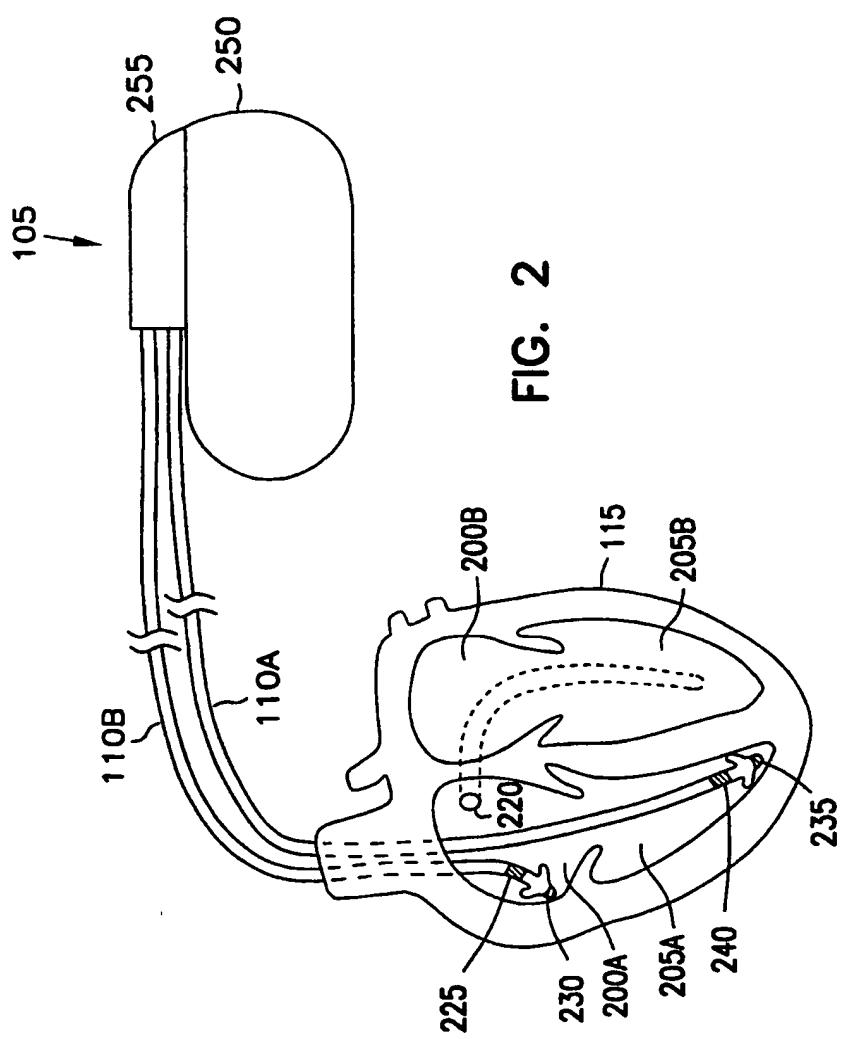
25. The method of claim 24, in which the third predetermined value is different when the most recent interval is initiated by a sensed beat than when the most recent interval is initiated by a paced beat.

5 26. The method of claim 19, in which stabilizing the rate includes:  
obtaining intervals between beats;  
computing a first indicated pacing interval based on at least a most recent interval duration and a previous value of the first indicated pacing interval; and  
providing a control signal, based on the first indicated pacing interval.

10

27. The method of claim 19, where detecting the episode includes detecting an atrial tachyarrhythmia, where stabilizing the rate includes stabilizing a ventricular heart rate at the variable indicated rate based on an underlying intrinsic ventricular heart rate, where determining if first types of conditions exist includes determining if potentially proarrhythmic conditions exist based on V-V intervals between ventricular events, and where providing the control signal includes delivering cardioversion/defibrillation therapy to the atrium if no potentially proarrhythmic conditions exist, otherwise withholding the delivery of cardioversion/defibrillation therapy to the atrium until no potentially 15 proarrhythmic conditions exist.  
20





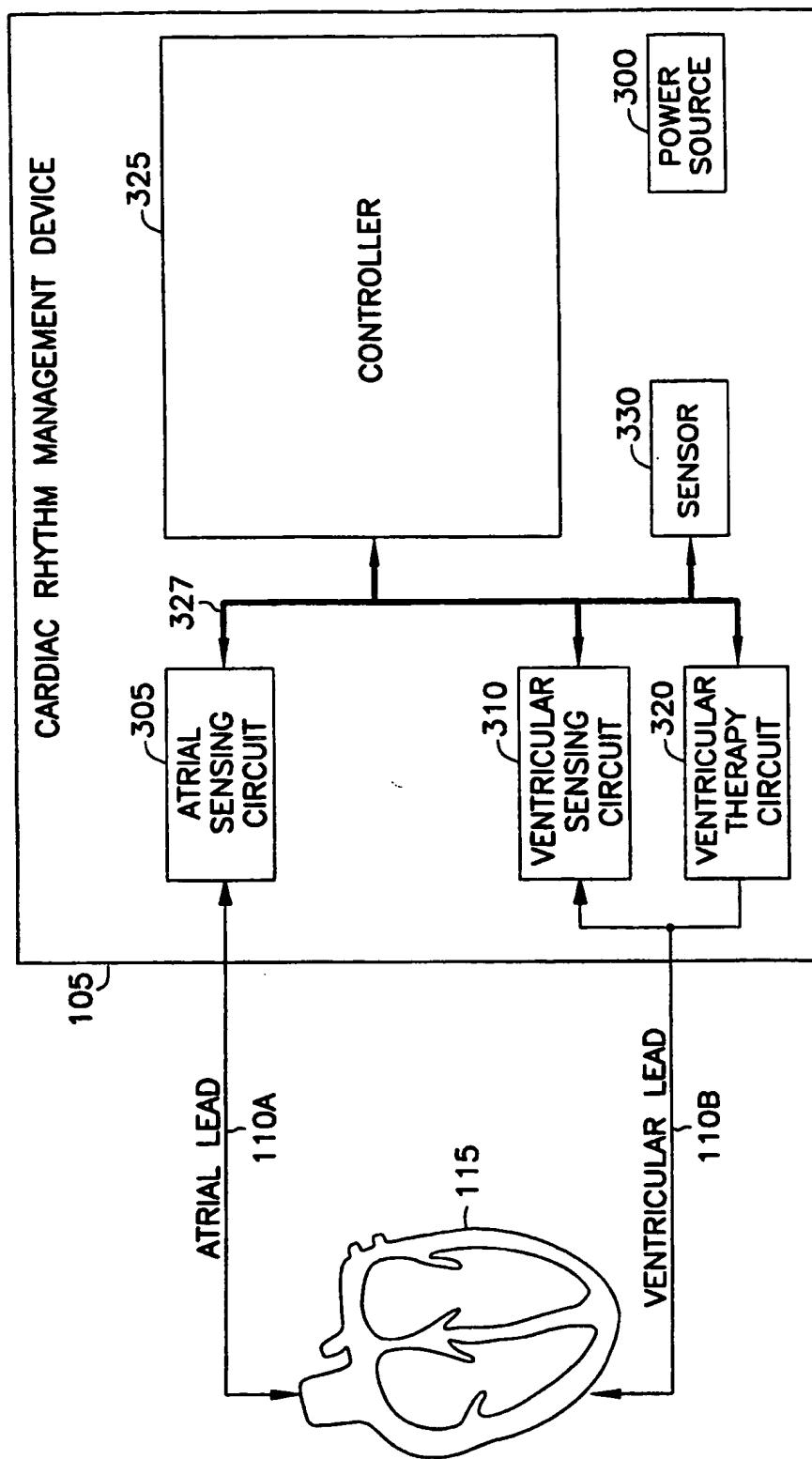


FIG. 3

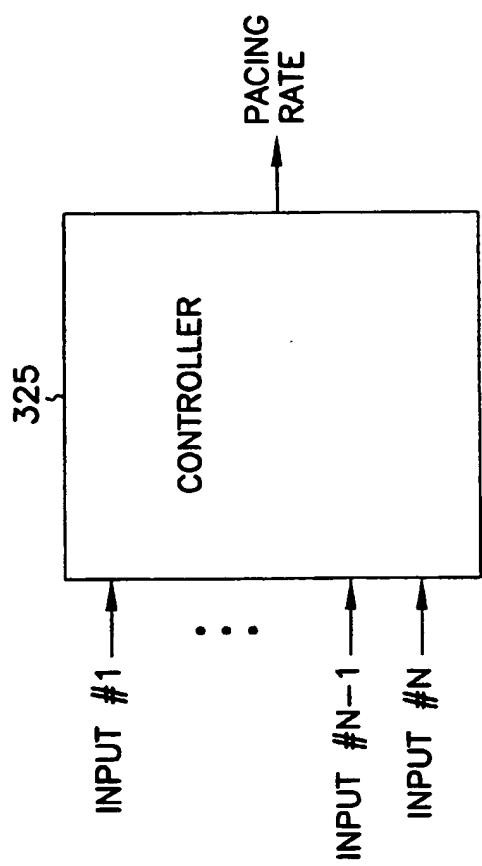


FIG. 4

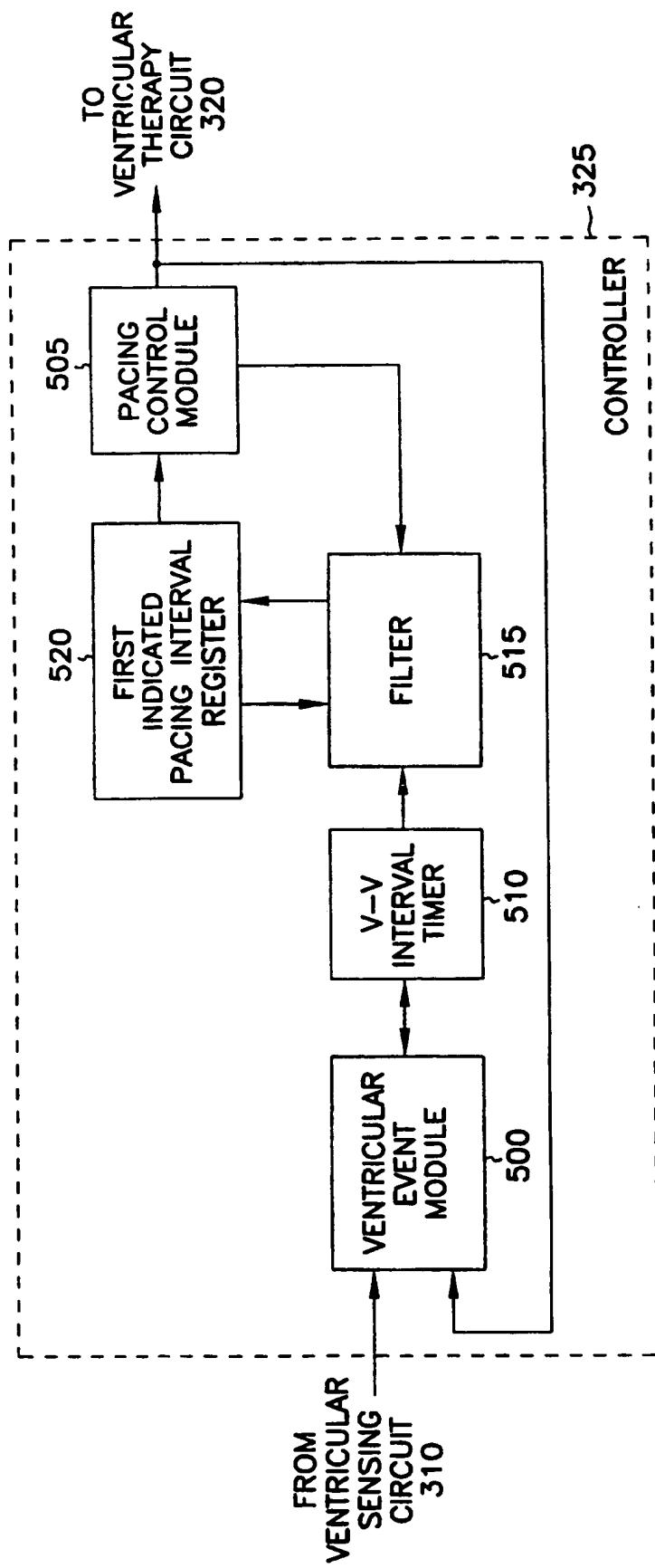


FIG. 5

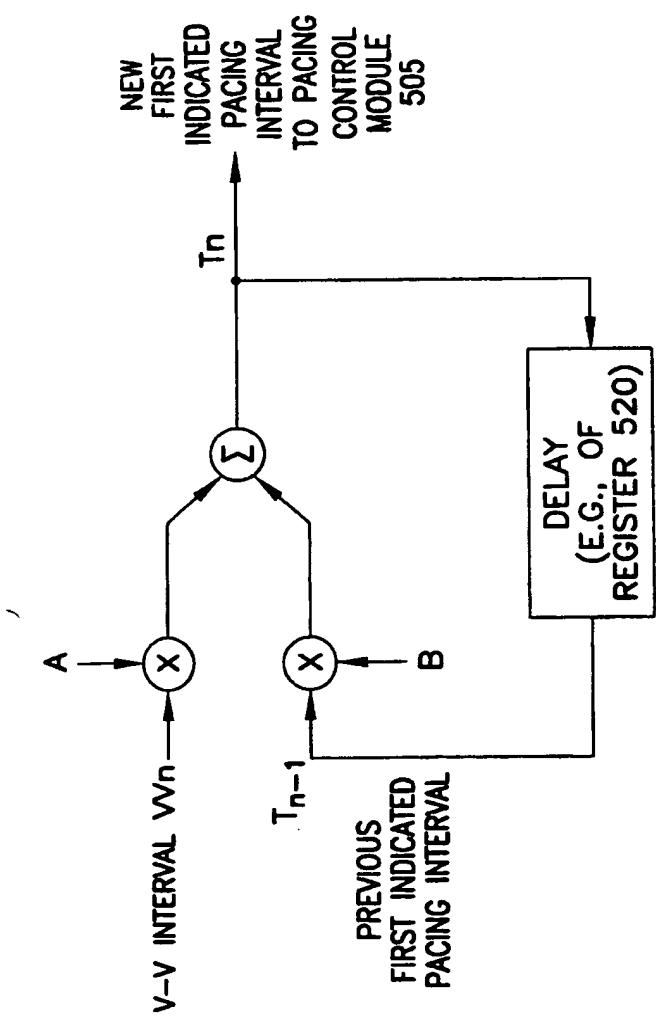


FIG. 6

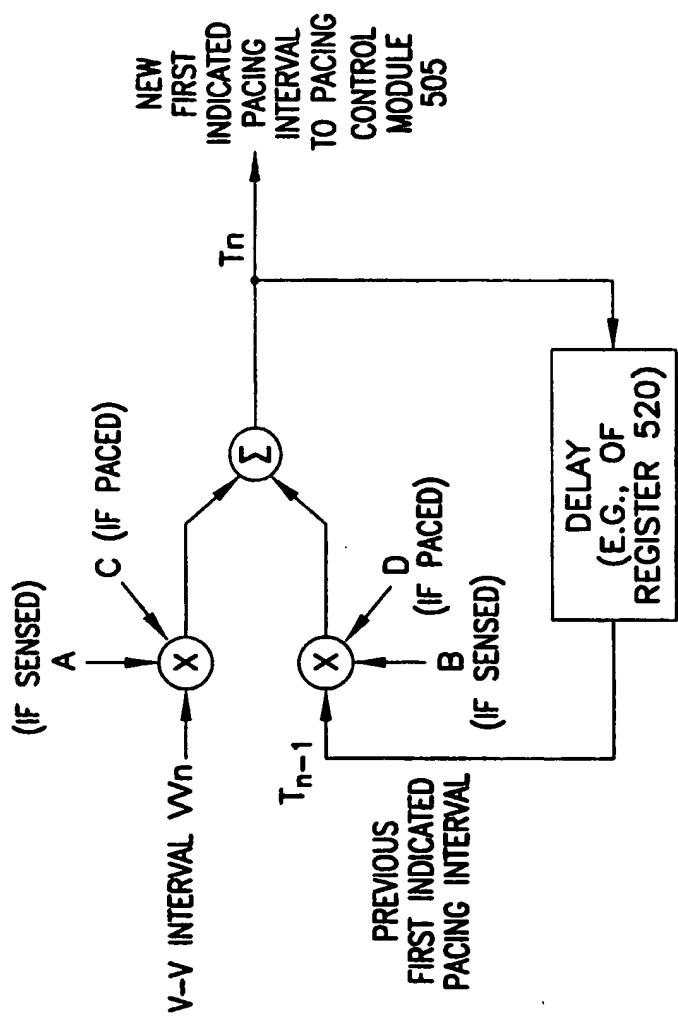


FIG. 7

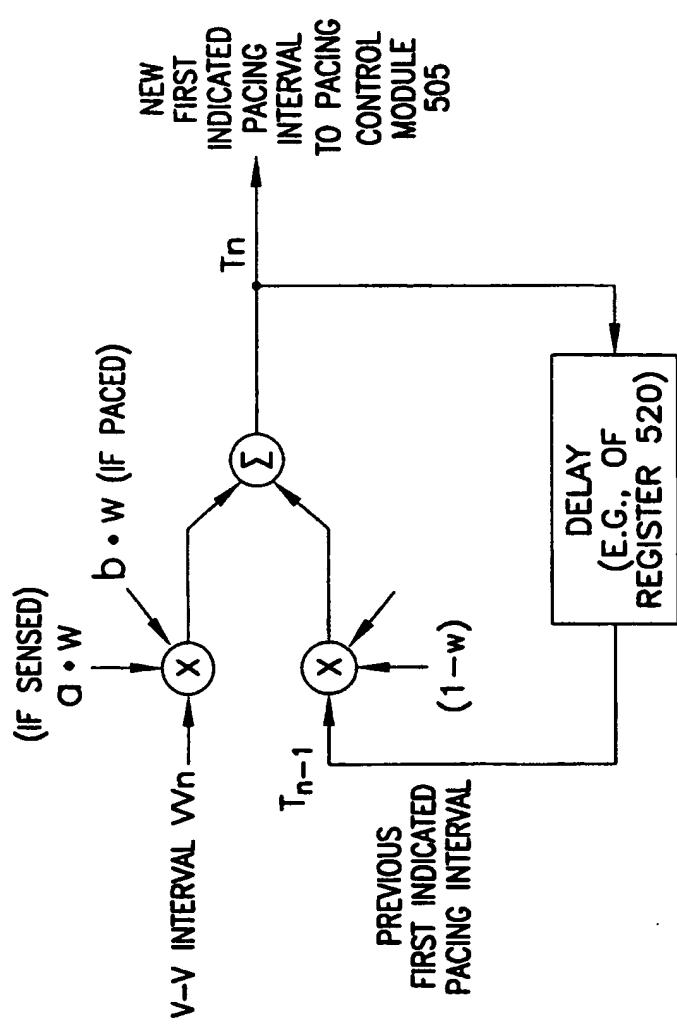


FIG. 8

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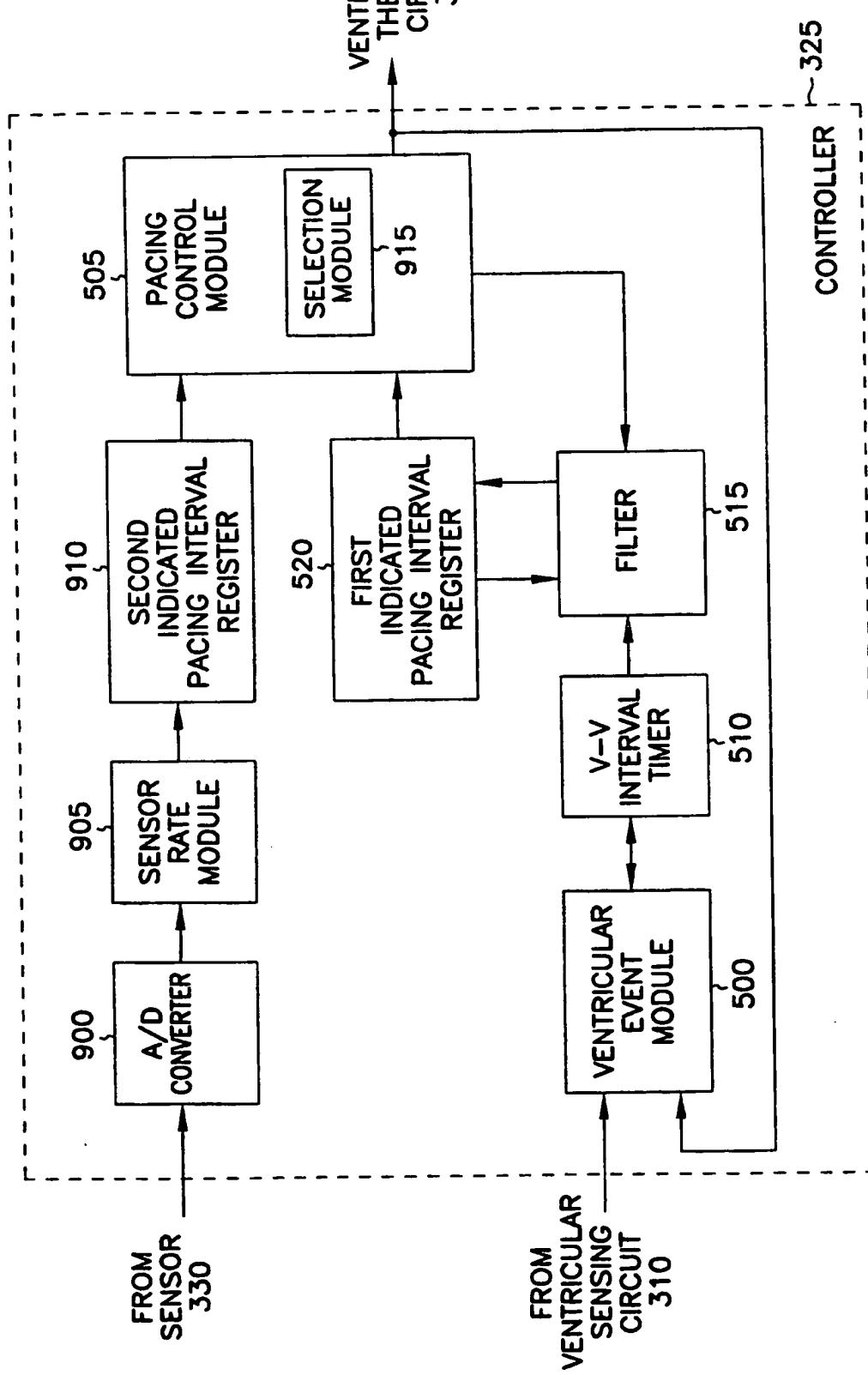
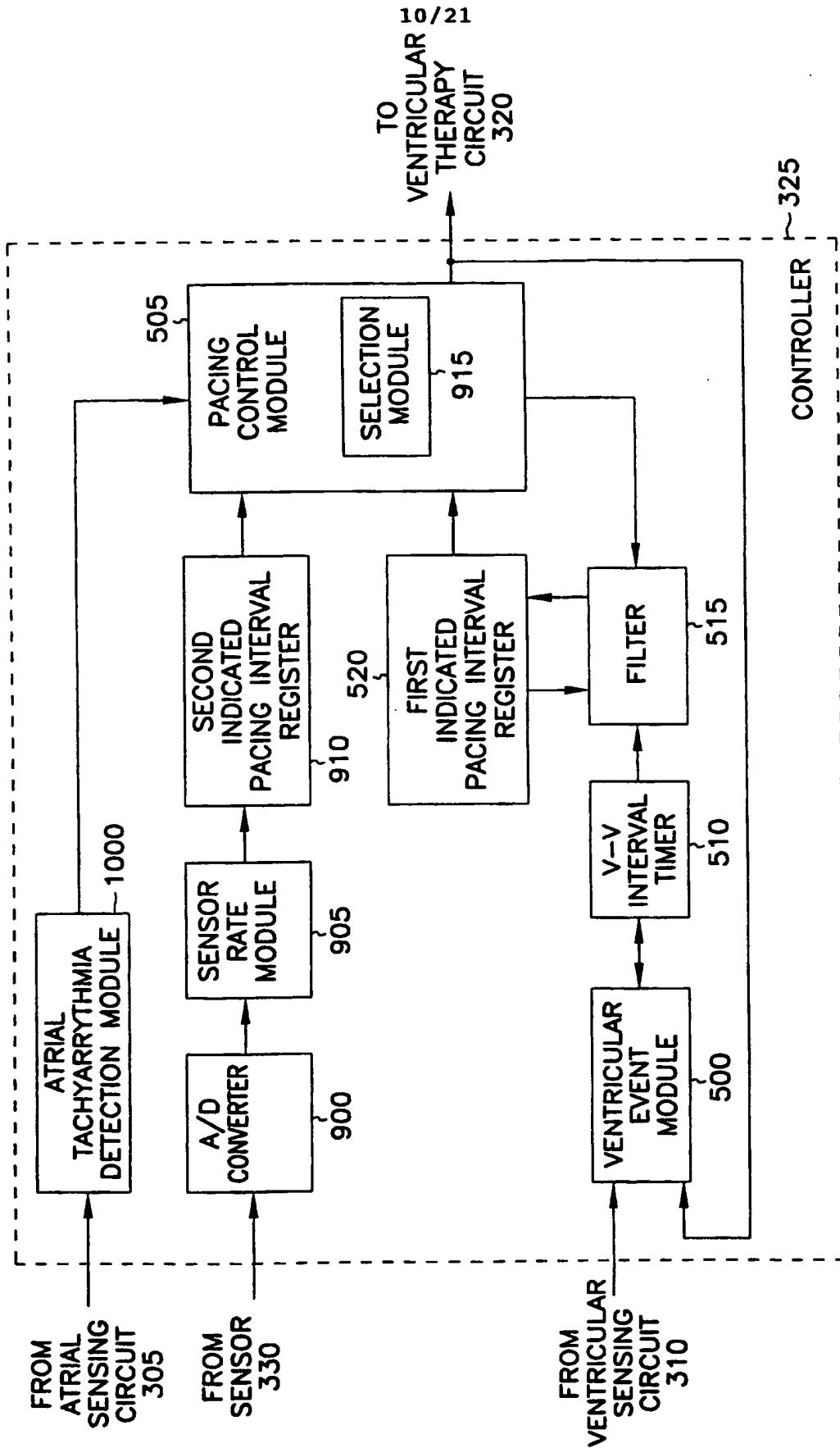
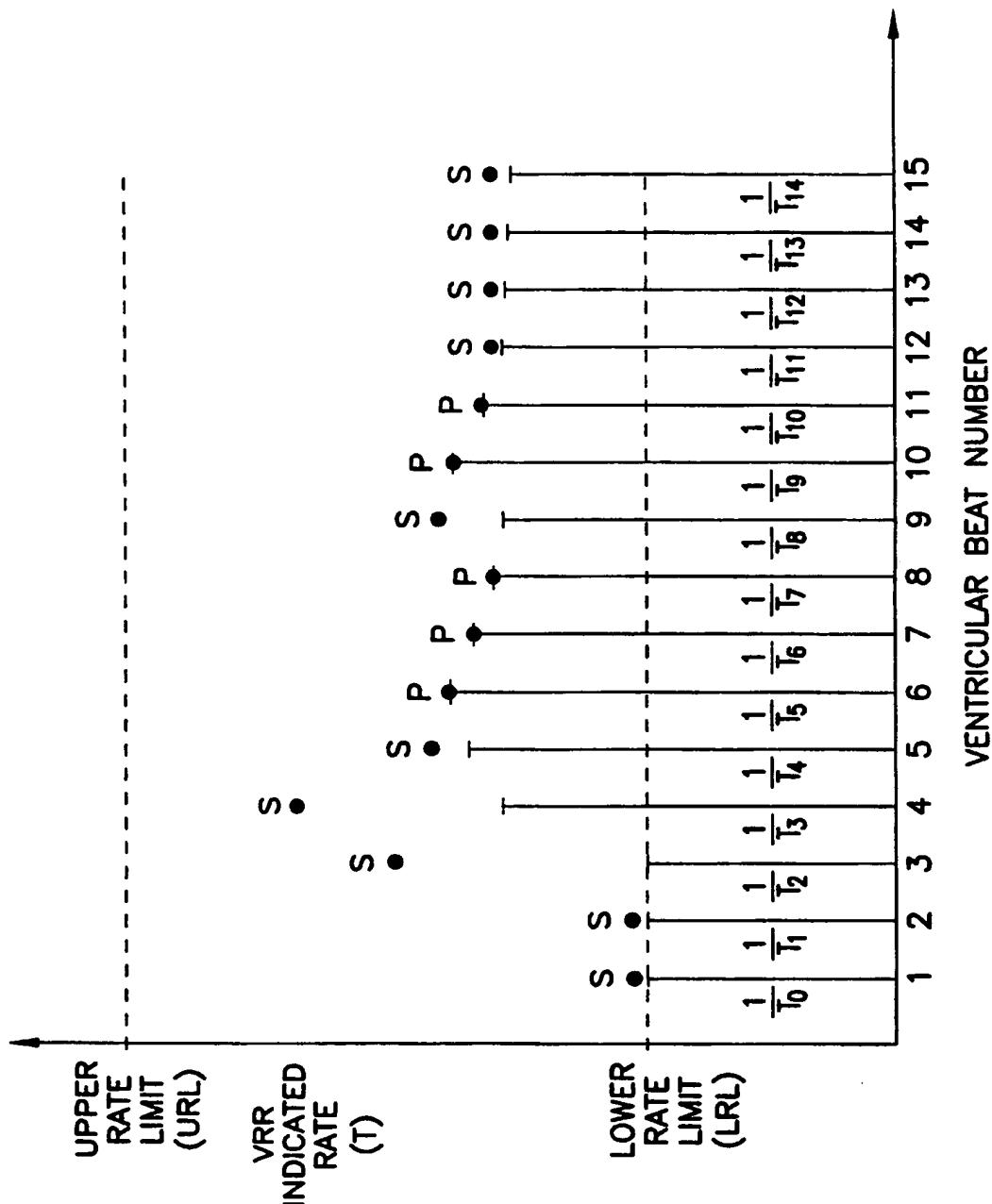


FIG. 9





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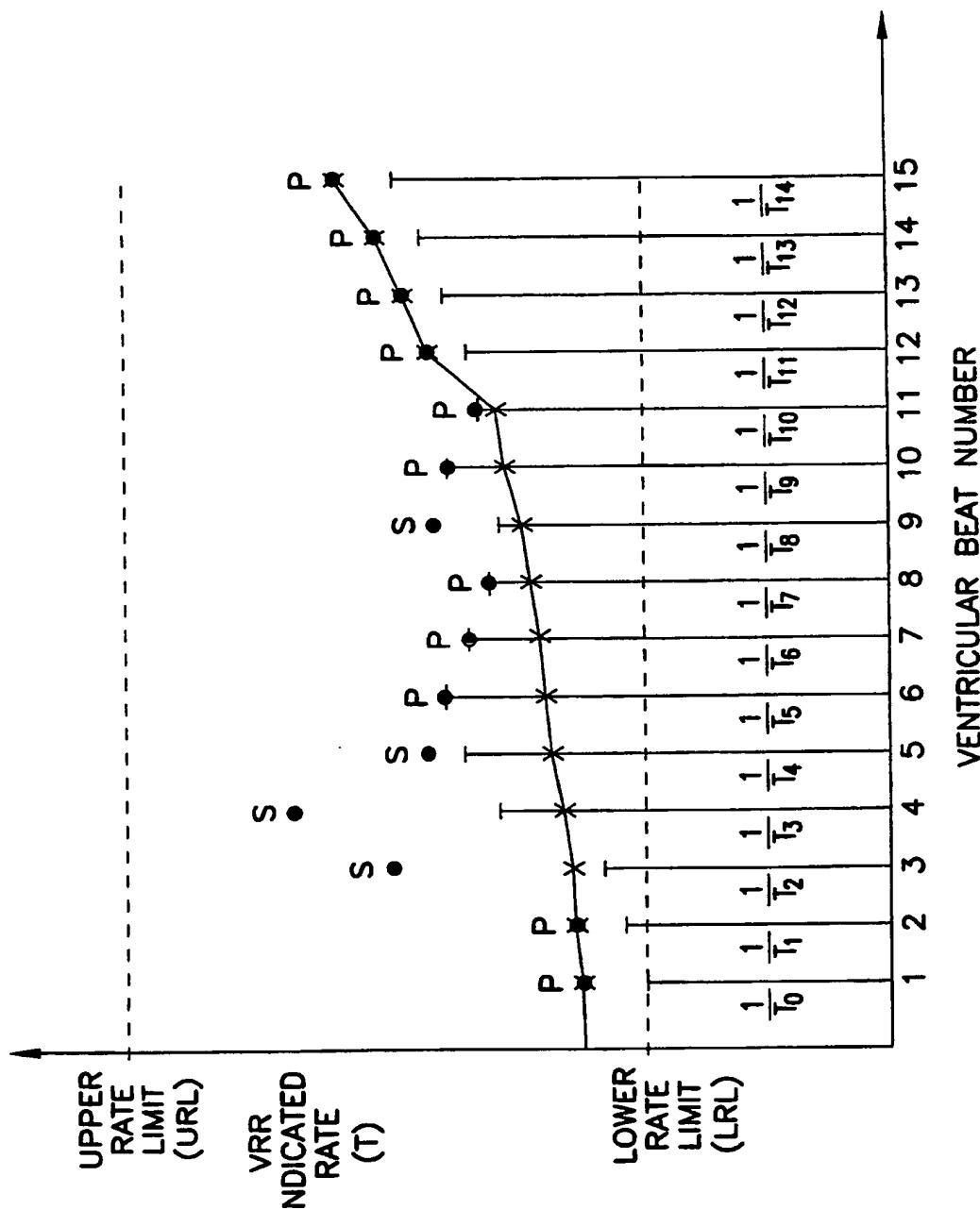


FIG. 12

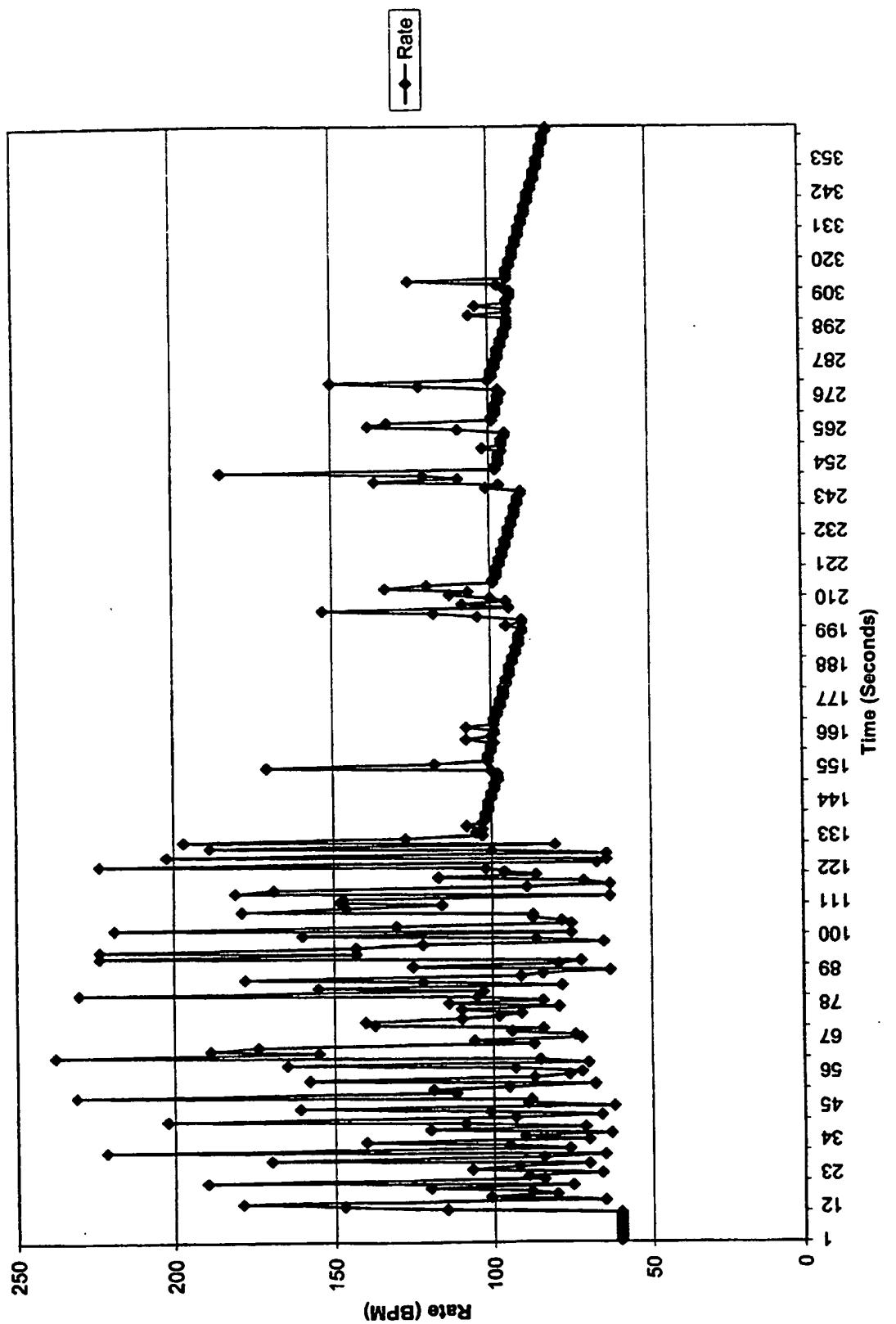


FIG. 13

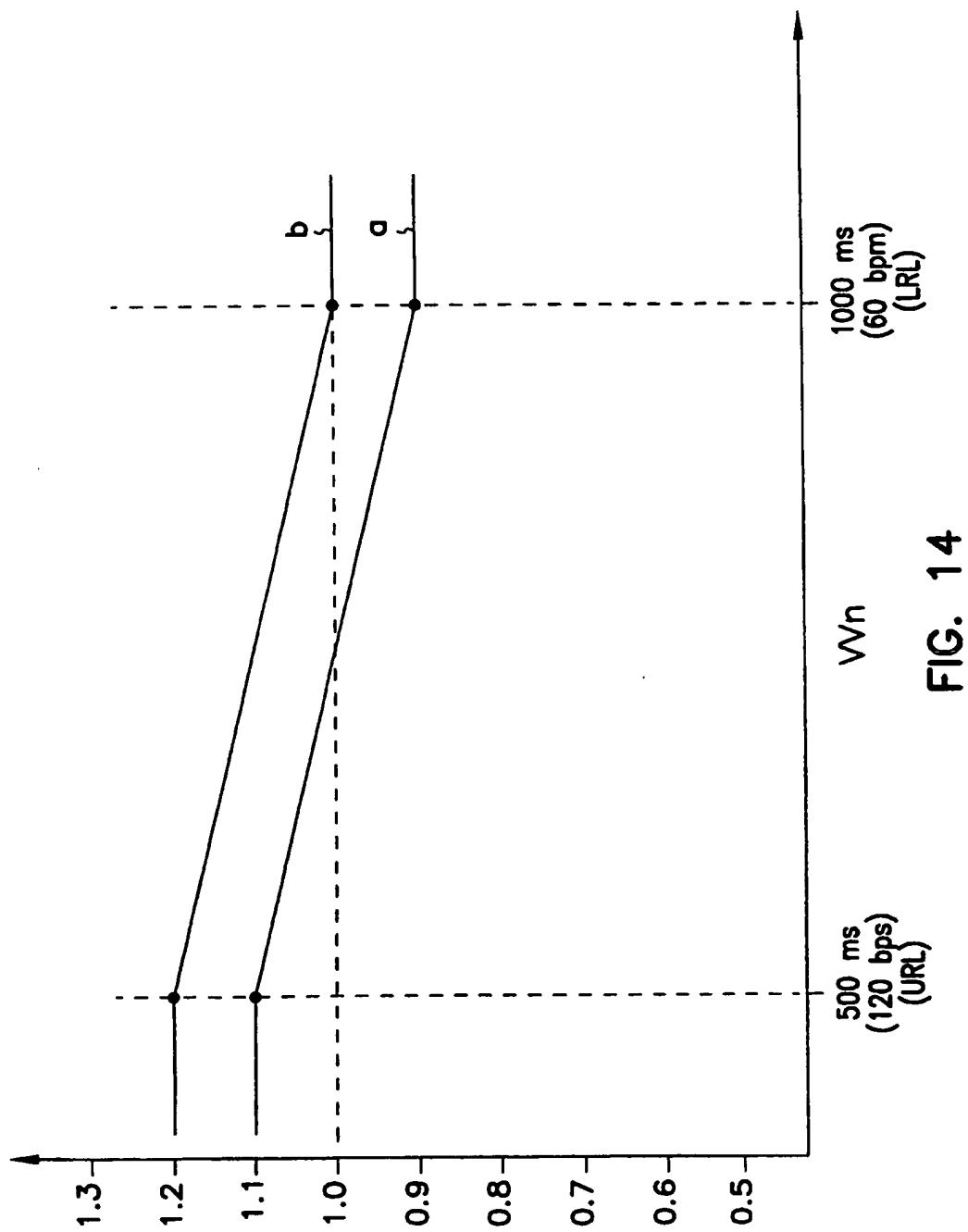
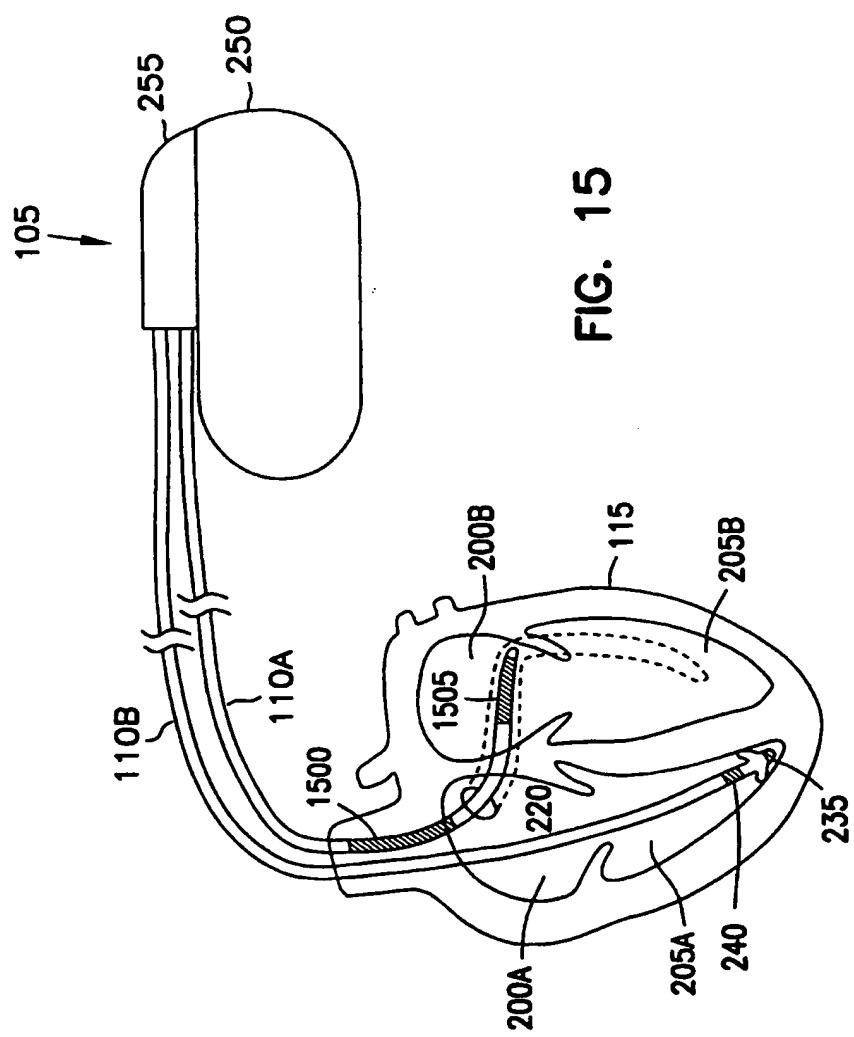


FIG. 15



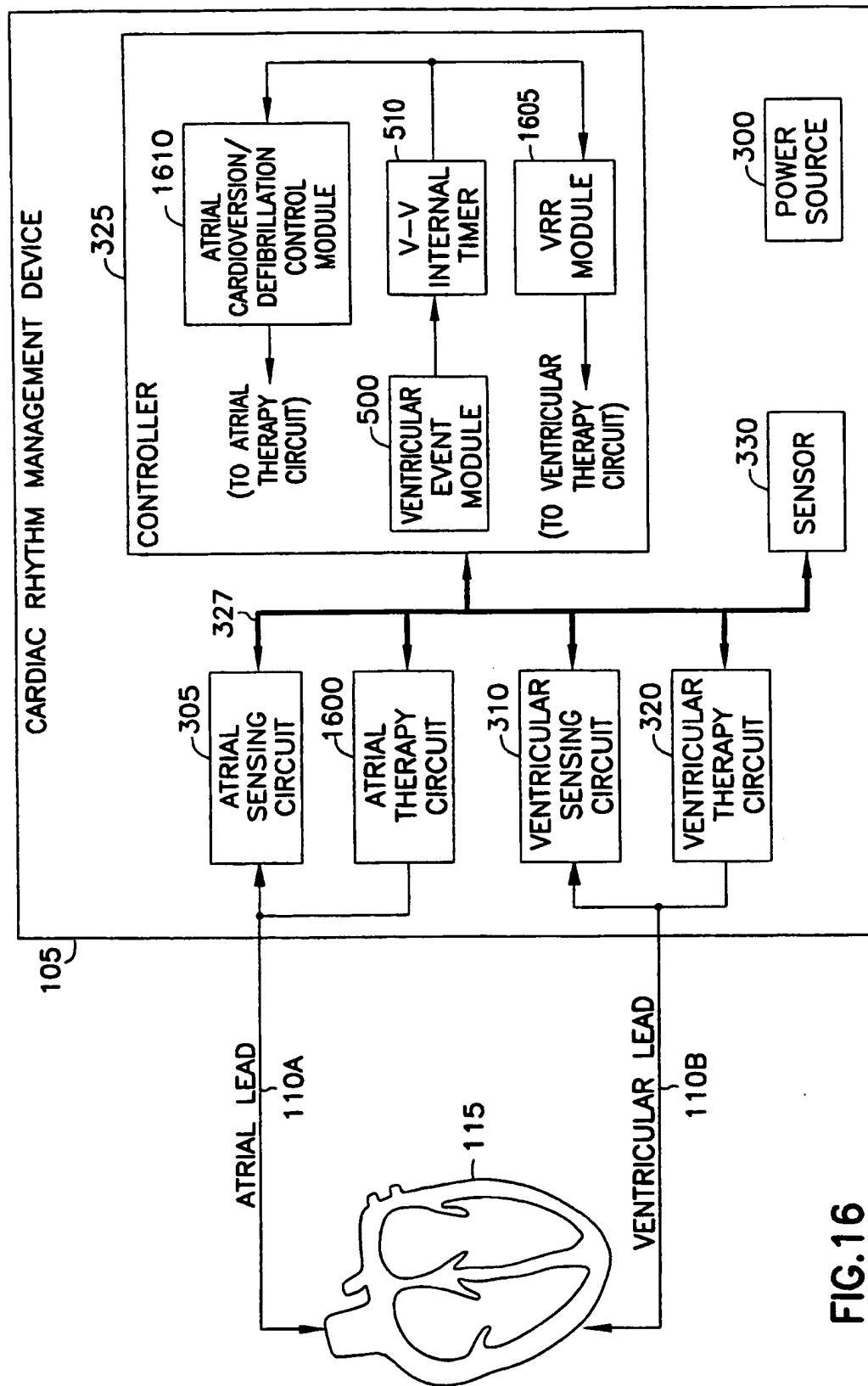


FIG. 16

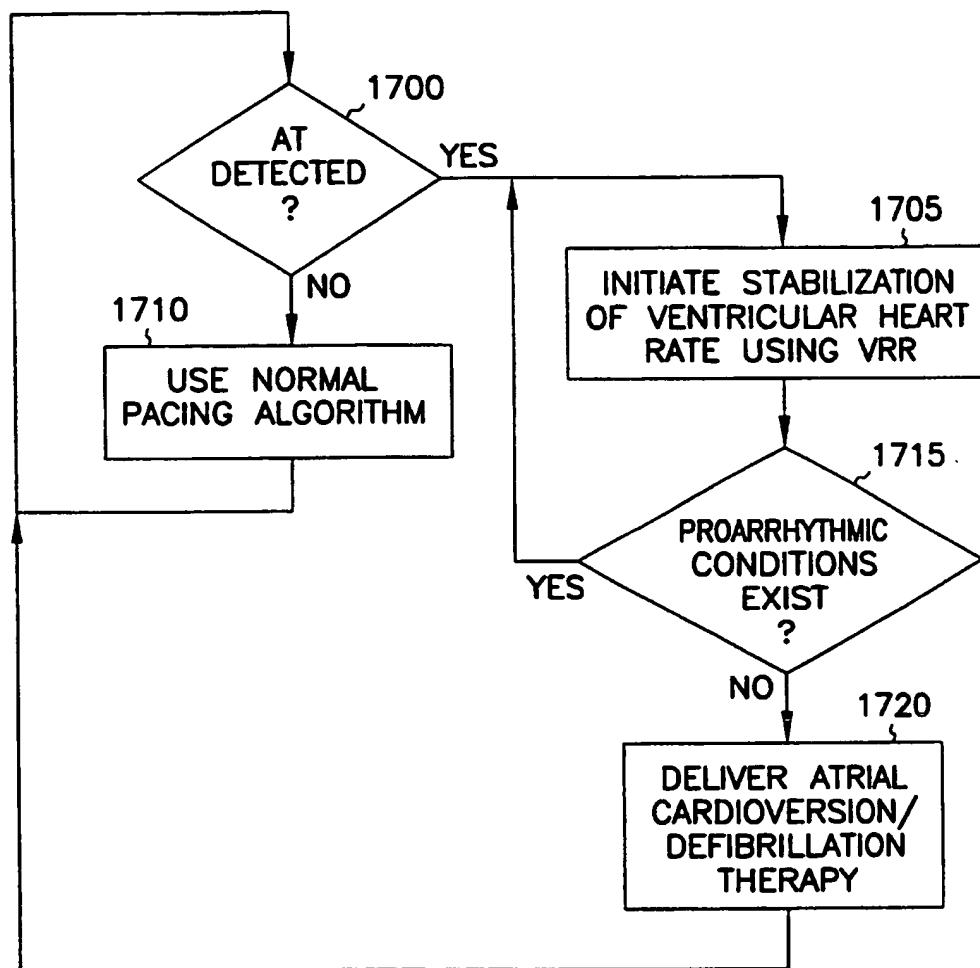


FIG. 17

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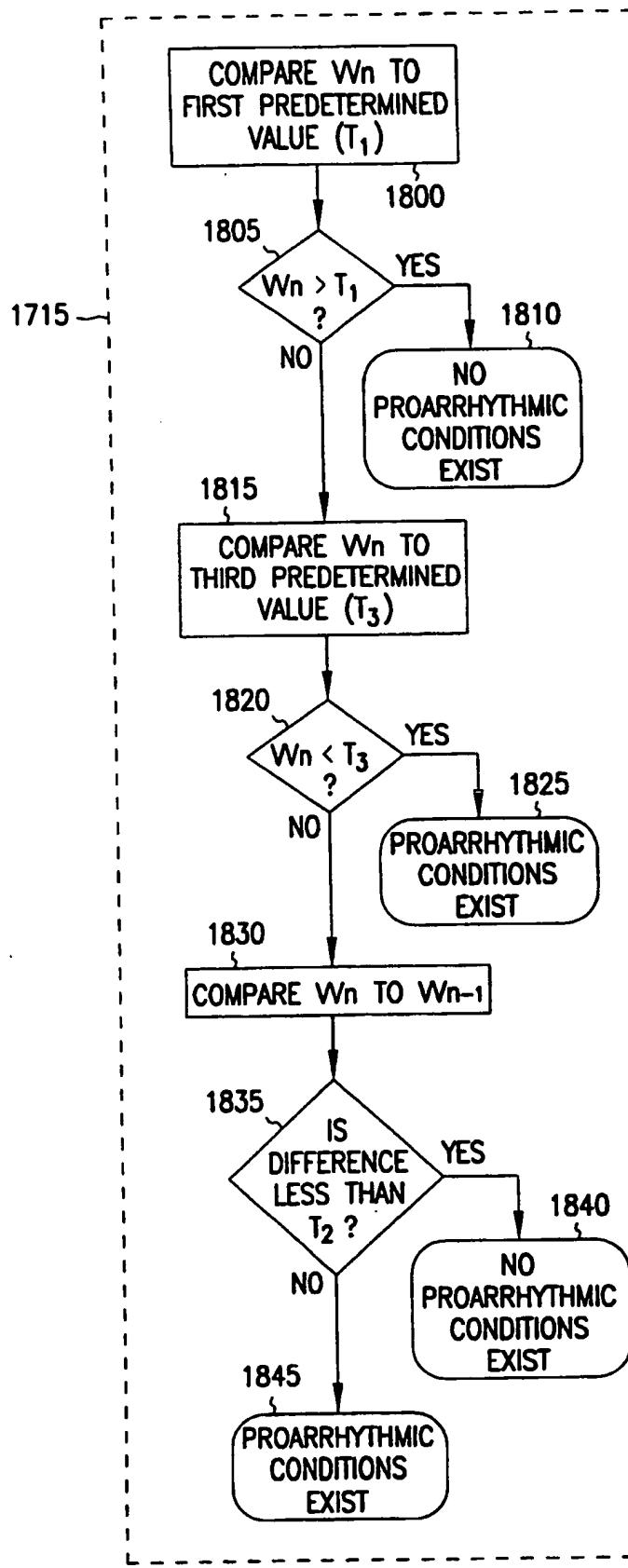


FIG. 18

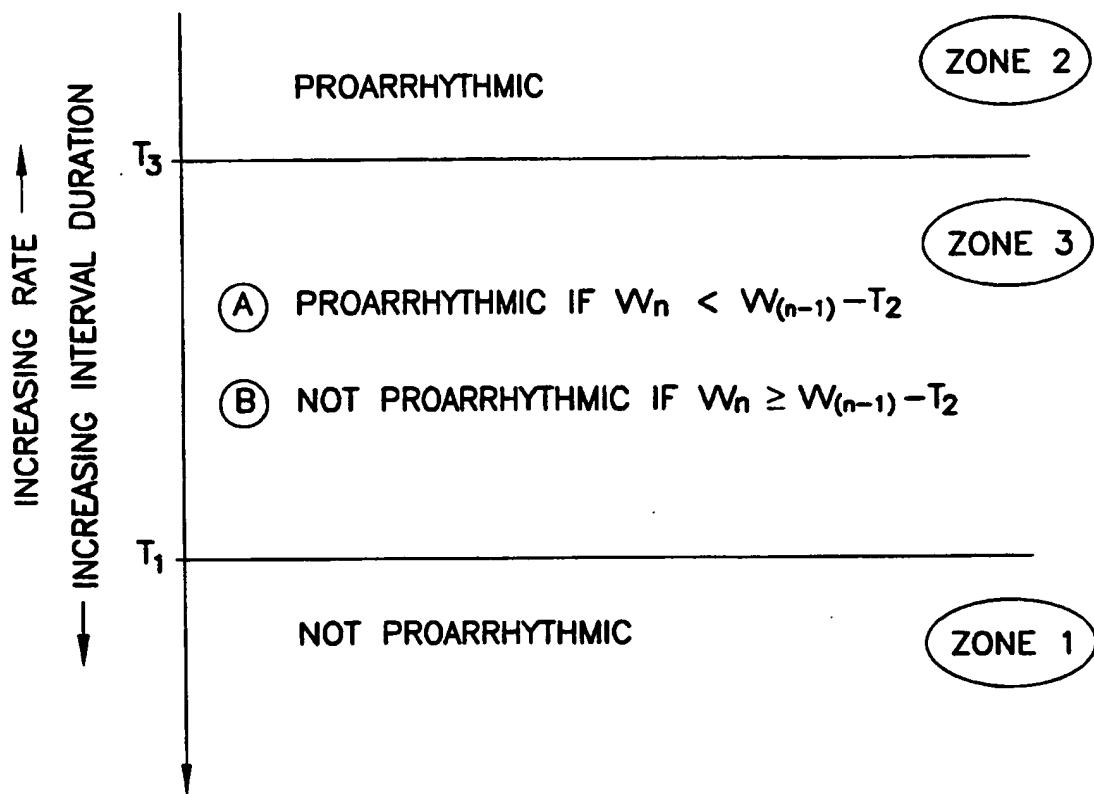


FIG. 19

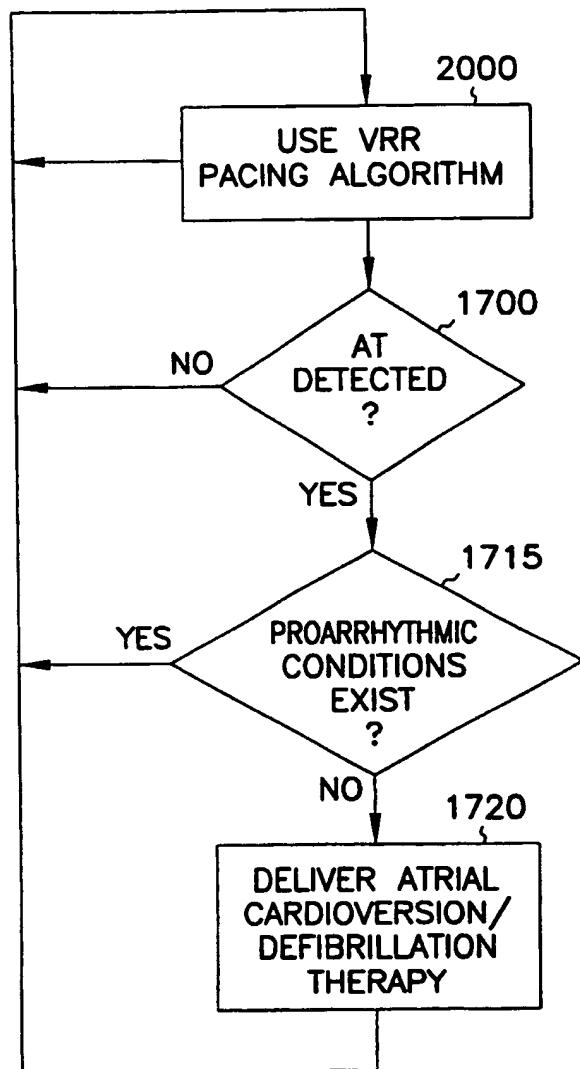


FIG. 20

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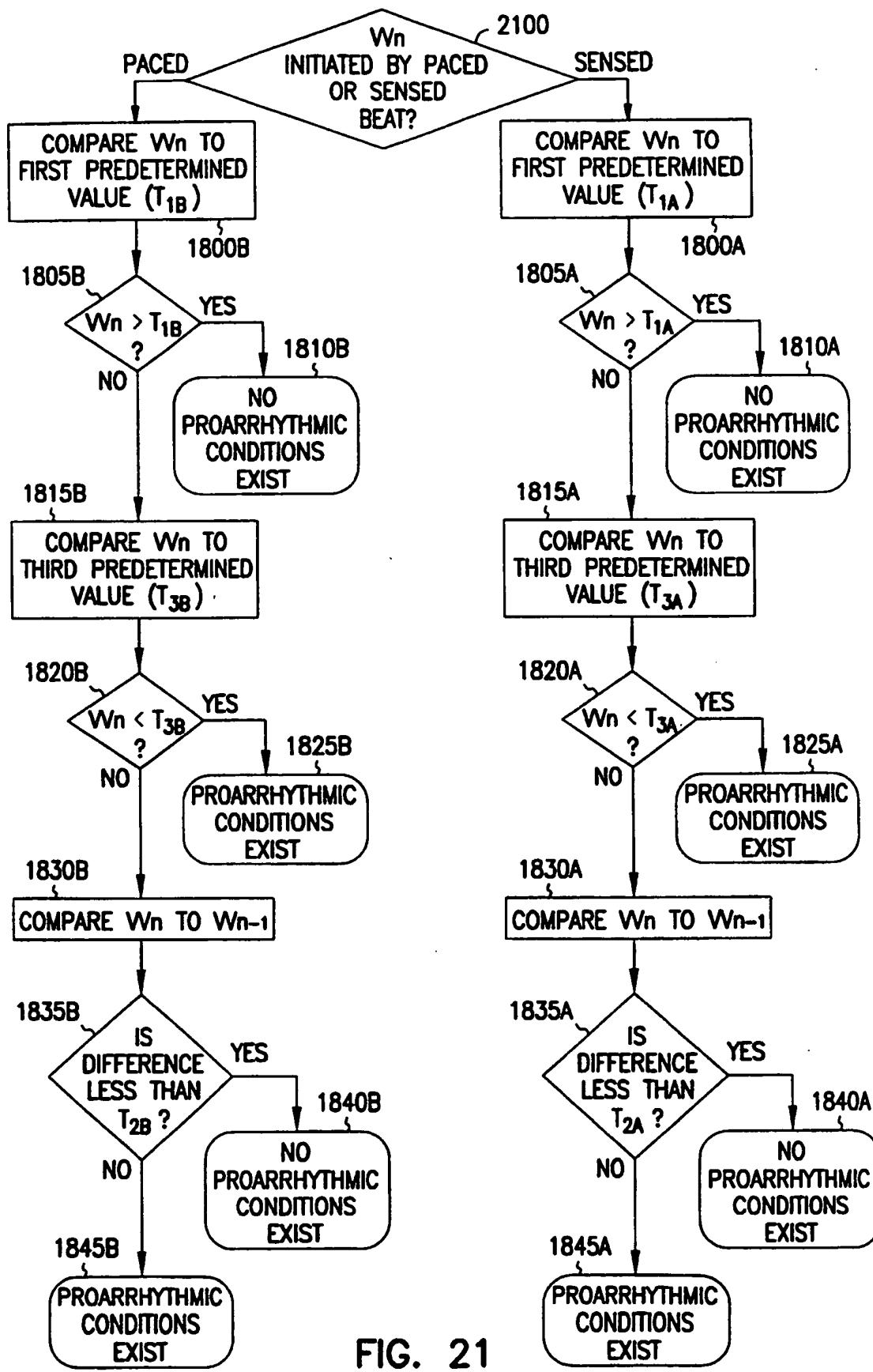


FIG. 21

# INTERNATIONAL SEARCH REPORT

Int'l Application No  
PCT/US 00/13838

**A. CLASSIFICATION OF SUBJECT MATTER**  
IPC 7 A61N1/39

According to International Patent Classification (IPC) or to both national classification and IPC

**B. FIELDS SEARCHED**

Minimum documentation searched (classification system followed by classification symbols)

IPC 7 A61N

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

EPO-Internal

**C. DOCUMENTS CONSIDERED TO BE RELEVANT**

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	WO 98 48891 A (KRIG ET AL) 5 November 1998 (1998-11-05) page 4, line 22 -page 6, line 12	1
Y	page 8, line 25 -page 9, line 16 page 13, line 3 - line 12 page 17, line 8 - line 22 page 21, line 14 - line 22 page 28, line 13 - line 19	2-5, 7-10,12, 14-18
Y	US 5 486 198 A (AYERS GREGORY M ET AL) 23 January 1996 (1996-01-23)	2-5, 7-10,12, 14-18
A	column 6, line 59 -column 9, line 10	1
	-/-	

Further documents are listed in the continuation of box C.

Patent family members are listed in annex.

\* Special categories of cited documents :

- "A" document defining the general state of the art which is not considered to be of particular relevance
- "E" earlier document but published on or after the international filing date
- "L" document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)
- "O" document referring to an oral disclosure, use, exhibition or other means
- "P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art.

"&" document member of the same patent family

Date of the actual completion of the international search

25 September 2000

Date of mailing of the international search report

02/10/2000

Name and mailing address of the ISA

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Authorized officer

Martelli, L

# INTERNATIONAL SEARCH REPORT

International Application No  
PCT/US 00/13838

## C(Continuation) DOCUMENTS CONSIDERED TO BE RELEVANT

Category	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
A	US 5 207 219 A (ADAMS JOHN M ET AL) 4 May 1993 (1993-05-04) column 5, line 24 - line 34 column 6, line 64 -column 8, line 9	1-4,7, 17,18

## INTERNATIONAL SEARCH REPORT

International application No.  
PCT/US 00/13838

### Box I Observations where certain claims were found unsearchable (Continuation of item 1 of first sheet)

This International Search Report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

1.  Claims Nos.: **19-27**  
because they relate to subject matter not required to be searched by this Authority, namely:  
**Rule 39.1(iv) PCT - Method for treatment of the human or animal body by therapy**
2.  Claims Nos.:  
because they relate to parts of the International Application that do not comply with the prescribed requirements to such an extent that no meaningful International Search can be carried out, specifically:
3.  Claims Nos.:  
because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

### Box II Observations where unity of invention is lacking (Continuation of item 2 of first sheet)

This International Searching Authority found multiple inventions in this international application, as follows:

1.  As all required additional search fees were timely paid by the applicant, this International Search Report covers all searchable claims.
2.  As all searchable claims could be searched without effort justifying an additional fee, this Authority did not invite payment of any additional fee.
3.  As only some of the required additional search fees were timely paid by the applicant, this International Search Report covers only those claims for which fees were paid, specifically claims Nos.:
4.  No required additional search fees were timely paid by the applicant. Consequently, this International Search Report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.:

#### Remark on Protest

The additional search fees were accompanied by the applicant's protest.

No protest accompanied the payment of additional search fees.

# INTERNATIONAL SEARCH REPORT

Information on patent family members

Int'l. Application No.  
PCT/US 00/13838

Patent document cited in search report		Publication date	Patent family member(s)		Publication date
WO 9848891	A	05-11-1998	US EP	5978707 A 0986419 A	02-11-1999 22-03-2000
US 5486198	A	23-01-1996	AU AU CA EP	685961 B 2840595 A 2154727 A 0696462 A	29-01-1998 22-02-1996 13-02-1996 14-02-1996
US 5207219	A	04-05-1993	AT AU AU CA DE DE EP ES JP JP	168025 T 657247 B 3293 A 20,5688 A,C 69319537 D 69319537 T 0594269 A 2118889 T 2563748 B 6178817 A	15-07-1998 02-03-1995 05-05-1994 24-04-1994 13-08-1998 29-10-1998 27-04-1994 01-10-1998 18-12-1996 28-06-1994